NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 23. BOARD OF PHARMACY

PREAMBLE

1.

Sections Affected	Rulemaking Action
R4-23-110	Amend
R4-23-202	Amend
R4-23-203	Amend
R4-23-204	Amend
R4-23-205	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. § 32-1904(A)(1), (2), and (5) and 32-1904(B)(7), (10), and (11.
Implementing statutes: A.R.S. §§ 32-1922, 32-1924(A), (B), (D), (E), and (F), 32-1925(A), (B), (C), and (E)(1), 32-1931, 32-1935, 32-1936, and 32-1937

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening, 7 A.A.R. 977, February 23, 2001.

4. The name and address of agency personnel with whom persons may communicate regarding the rule:

Name: Dean Wright, Compliance Officer

Address: Board of Pharmacy
4425 W. Olive Ave., Suite 140
Glendale, AZ 85302

Telephone: (623) 463-2727 ext. 131

Fax: (623) 934-0583

E-mail: rxcop@qwest.net

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The Board voted to increase the pharmacist license and pharmacy permit fees at the January 2001 Board meeting. The increases are necessary to accommodate an ever increasing budget. Additional changes in Sections R4-23-202 and R4-23-203 will clarify the requirements and procedures for licensure by examination and reciprocity. Board staff pointed out that the examination fee in R4-23-205 was only being required of applicants for licensure by examination and not applicants by reciprocity. A.R.S. § 32-1922(A)(5) mandates an examination fee for all pharmacist licensure applicants. The existing examination fees in R4-23-205 do not correspond to the fees that are actually collected by Board office personnel. The proposed rule reflects an examination fee of $50 that will be paid by all applicants (by examination or reciprocity). Existing rule had a $100 examination fee for the initial AZPLEX examination and $50 examination fee to retake the AZPLEX. In practice, only the licensure by examination applicants, who take both NAPLEX and AZPLEX, paid the $100 examination fee, and the licensure by reciprocity applicants, who only take

the AZPLEX, paid no examination fee. The examinations (NAPLEX and AZPLEX) are computer-based examinations that are approved by the Board and administered by NABP. The use of the NAPLEX and AZPLEX allows applicant's a choice between many locations in this and other states for taking the examinations. This decreases the time needed to become licensed. During the five-year rule review in September 1997, the Board determined that R4-23-204 should be amended by moving definitions in subsection (B) into R4-23-110. Other changes may be necessary to comply with the current Administrative Procedure Act and to provide a clear, concise, and understandable document.

The Board believes that approval of these rules will benefit the public health and safety by establishing clear standards governing pharmacist licensure and continuing education. The Board further believes that the fee increase is necessary to cover an increasing budget and support a Board staff dedicated to protecting public health and safety.

6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study, and other supporting material:

Not applicable

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

The proposed rule will impact the Board, pharmacists, and pharmacies. Some of the changes to the rule have no economic impact, but rather provide more clear, concise, and understandable language.

After conferring with the Joint Legislative Budget Committee, the Board determined that a fee increase for pharmacists and pharmacies is necessary to provide a needed budget increase to cover the costs of adding one new compliance officer and two non-pharmacist inspectors to the staff. A continuing increase in the number of pharmacies, drug wholesalers, nonprescription drug retailers, and other drug outlets in the state has put extreme pressure on the existing Board staff. The number of pharmacies in the state as of June 30, 2000 was 870. That is an increase of 21% since June 30, 1986 when there were 721 pharmacies in Arizona. The number of pharmacists with active in-state licenses as of June 30, 2000 was 3629. That is an increase of 57% since June 30, 1986 when there were 2315 active in-state pharmacists. The Board employed four full-time compliance officers in 1986 and still employs only four full-time compliance officers today. The Board has lost four compliance officers in the last four years because pharmacist compliance officer's salaries have not keep pace with the pharmacist salaries offered by community and hospital pharmacies. The 2001 Arizona Legislature approved the Board's 2002-2004 biennial budget to include a salary increase for pharmacist compliance officers and one additional compliance officer and two non-pharmacist inspectors. To support this budget increase, the Board approved a fee increase (within the allowed statutory maximum) for the pharmacist license and pharmacy permit. The pharmacist licensure fee increases to $145 biennially from $110 biennially. The pharmacy permit fee increases to $400 biennially from $300 biennially. The increased fees will not go into effect until the first renewal period after the effective date of the final rule.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Dean Wright, Compliance Officer
Address:	Board of Pharmacy 4425 W. Olive Ave., Suite 140 Glendale, AZ 85302
Telephone:	(623) 463-2727 ext. 131
Fax:	(623) 934-0583
E-mail:	rxcop@qwest.net

10. The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:
Comments may be written or presented orally. Written comments must be received by 5 p.m., Monday, October 1, 2001. An oral proceeding is scheduled for:

Date:	October 1, 2001
Time:	10:00 a.m.

Location: Board of Pharmacy
4425 W. Olive Ave., Suite 140
Glendale, AZ 85302

A person may request information about the oral proceeding by contacting the person listed above.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

None

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 23. BOARD OF PHARMACY

ARTICLE 1. ADMINISTRATION

Section
R4-23-110. Definitions

ARTICLE 2. PHARMACIST REGISTRATION

Section
R4-23-202. Licensure by Examination
R4-23-203. Licensure by Reciprocity
R4-23-204. Continuing Education Requirements
R4-23-205. Fees

ARTICLE 1. ADMINISTRATION

R4-23-110. Definitions

"Active ingredient" means any component that furnishes pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease or that affects the structure or any function of the body of man or other animals. The term includes those components that may undergo chemical change in the manufacture of the drug, that are present in the finished drug product in a modified form, and that furnish the specified activity or effect.

"Approved course in pharmacy law" means a continuing education activity that addresses practice issues related to state or federal pharmacy statutes, rules, or regulations.

"Approved Provider" means an individual, institution, organization, association, corporation, or agency that has been approved by the American Council on Pharmaceutical Education (A.C.P.E.) in accordance with its policy and procedures or by the Board as having met criteria indicative of the ability to provide quality continuing education.

"Authentication of product history" means identifying the purchasing source, the ultimate fate, and any intermediate handling of any component of a radiopharmaceutical or other drug.

"Container" means:

A receptacle, as described in the official compendium or the federal act, that is used in manufacturing or compounding a drug or in distributing, supplying, or dispensing the finished dosage form of a drug; or

A metal receptacle designed to contain liquefied or vaporized compressed medical gas and used in manufacturing, transvaluing, distributing, supplying, or dispensing a compressed medical gas.

"Continuing education" means a structured learning process by a pharmacist to maintain licensure that includes study in the general areas of socio-economic and legal aspects of health care; the properties and actions of drugs and dosage forms; etiology, characteristics and therapeutics of disease status; and pharmacy practice.

"Continuing education activity" means methods of learning that consist of institutes, seminars, lectures, conferences, workshops, various forms of mediated instruction, programmed learning courses, or postgraduate studies in an accredited college or school of pharmacy.

"Continuing education unit" or "CEU" means 10 contact hours of participation in a continuing education activity sponsored by an Approved Provider.

"Contact hour" means 50 minutes of participation in a continuing education activity sponsored by an Approved Provider.

"Correctional facility" has the same meaning as in A.R.S. §§ 13-2501 and 31-341.

"Mediated instruction" means information transmitted via intermediate mechanisms such as audio or video tape or telephone transmission.

"MPJE" means Multistate Pharmacy Jurisprudence Examination.
"NABP" means National Association of Boards of Pharmacy.

ARTICLE 2. PHARMACIST REGISTRATION

R4-23-202. Licensure by Examination

A. Eligibility~~:~~. To be eligible for licensure as a pharmacist by examination, a person shall:
1. Have an undergraduate or first professional degree in pharmacy from a school or college of pharmacy whose professional degree program, at the time the person graduates, is accredited by the American Council on Pharmaceutical Education~~,~~; or
2. Qualify under the requirements of A.R.S. § 32-1922(C); and

~~2.~~3. Complete not less than 1500 hours of intern training as specified in R4-23-303.

B. Application~~:~~.
1. An applicant for licensure by examination shall file with the Board:
   a. A completed ~~application~~ Application for Licensure by Examination form, ~~at least 30 days before the date of the AZPLEX, and~~
   b. A completed NAPLEX registration form ~~for the NAPLEX at least 30 days before the applicant's preferred NAPLEX testing window~~ or an Official NABP Score Transfer Report through the Board Office online computer link with NABP indicating the applicant's score on the NAPLEX taken in another jurisdiction, and
   c. A completed AZPLEX registration form.
2. The Board Office shall deem an application ~~form~~ or registration form received on the date that the Board Office stamps on the form as the form is delivered to the Board Office and a score transfer received on the date that the NABP transmits the applicant's Official NABP Score Transfer Report through the online computer link to the Board Office.
3. An applicant for licensure by examination shall:
   a. ~~make~~ Make application ~~for licensure by examination~~ on a form furnished by the Board, and
   b. ~~shall submit~~ Submit with the ~~application~~ Application for Licensure by Examination form~~,~~:
      i. The documents specified in the application form, and
      ii. The examination fee specified in R4-23-205(C)~~(1)(a). The fee shall be paid~~ and made payable to the Arizona State Board of Pharmacy by money order or certified or personal check.
4. An applicant for licensure by examination shall:
   a. ~~make~~ Make ~~the~~ NAPLEX and AZPLEX registration on ~~a form~~ forms furnished by the Board or NABP; and
   b. ~~shall submit~~ Submit with the registration ~~form~~ forms~~,~~:
      i. ~~the~~ The documents specified in the registration ~~form~~ forms~~,~~; and
      ii. ~~the~~ The examination fee specified by ~~NABP. The fee shall be~~ and made payable to NABP by money order, certified check, or bank draft.
5. The Board shall deem ~~a~~ an Application for Licensure by Examination or NAPLEX or AZPLEX registration ~~or AZPLEX application for licensure by examination~~ to be invalid after 12 months from the date the Board Office determines an application or registration form is complete. An applicant whose application or registration form is invalid and who wishes to continue licensure procedures, shall submit a new application ~~form~~ or registration form and fee.

C. Passing grade; notification; re-examination~~:~~.
1. To pass the required examinations, an applicant shall obtain a score of at least 75 on both the NAPLEX and ~~75% on the~~ AZPLEX.
2. The ~~NABP will forward~~ Board Office shall:
   a. Retrieve an applicant's NAPLEX and AZPLEX score ~~to the Board~~ from the NABP online database no later than ~~2~~ two weeks after the applicant's examination date~~.~~; and
   b. ~~The Board Office shall~~ Mail ~~the~~ an applicant's NAPLEX and AZPLEX score to ~~an~~ the applicant no later than ~~7~~ seven days after the Board Office receives the applicant's score from NABP.

~~3. The Board Office shall mail an applicant's AZPLEX score to the applicant no later than 14 days after the applicant takes the examination.~~

~~4.~~3. An applicant who fails the NAPLEX or AZPLEX may apply to ~~take a subsequent~~ retake an examination within the 12-month-application period defined in subsection(B)(5). An applicant applying to ~~take a subsequent~~ retake an examination shall submit to the Board Office a completed NAPLEX or AZPLEX registration form and pay the examination fee specified by ~~NABP. The fee shall be~~ and made payable to NABP by money order, certified check, or bank draft. An applicant who fails the NAPLEX or AZPLEX ~~3~~ three times shall petition the Board for permission before retaking the examination.

~~5. An applicant who fails the AZPLEX may apply for reexamination within the 12-month-application period defined in subsection(B)(5).An applicant applying for reexamination shall submit to the Board Office a written request to retake the AZPLEX including the examination date preferred by the applicant and pay the examination fee specified in R4-~~

~~23-205(C) (1)(b). The fee shall be paid to the Arizona State Board of Pharmacy by money order or certified or personal check. An applicant who fails the AZPLEX 3 times shall petition the Board for permission before retaking the examination.~~

D. NAPLEX score transfer~~:~~.

1. An applicant who receives a passing score on the NAPLEX taken in another jurisdiction shall complete the licensure procedure within 12 months from the date the Board receives the applicant's Official NABP Score Transfer Report from the NABP by making application for licensure according to subsection (B)~~(3)~~ of this Section. After 12 months, an applicant may apply for licensure in Arizona under the provisions of R4-23-202(B) or R4-23-203(B).
2. An applicant who takes the NAPLEX in another jurisdiction and fails the examination may apply for licensure in Arizona under the provisions of R4-23-202(B)

E. Licensure~~:~~. The Board shall issue a certificate of licensure to a successful applicant upon receipt of the licensure fee specified in R4-23-205(A)(1)(a). The Board Office shall:

1. Provide a receipt for payment of the licensure fee to an applicant who delivers a payment in person, or
2. ~~mail~~ Mail a receipt for payment of the licensure fee to ~~the~~ an applicant within ~~1~~ one working day of receiving the payment by mail or other delivery service.

F. Time-frames for licensure by examination~~:~~.

1. The Board Office shall finish an administrative completeness review within 20 days from the date of receipt of an application or registration form.
   a. The Board Office shall issue a written notice of administrative completeness to the applicant if no deficiencies are found in the application or registration form.
   b. If the application or registration form is incomplete, the Board Office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 20-day time-frame for the Board Office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board Office with all missing information.
   c. If the Board Office does not provide the applicant with notice regarding administrative completeness, the application or registration form shall be deemed complete 20 days after receipt by the Board Office.
2. An applicant with an incomplete application or registration form shall submit all of the missing information within 30 days of service of the notice of incompleteness.
   a. If an applicant cannot submit all missing information within 30 days of service of the notice of incompleteness, the applicant may obtain an extension by submitting a written request to the Board Office post marked or delivered no later than 30 days from service of the notice of incompleteness.
   b. The written request for an extension shall document the reasons the applicant is unable to meet the 30-day deadline.
   c. The Board Office shall review the request for an extension of the 30-day deadline and grant the request if the Board Office determines that an extension of the 30-day deadline will enable the applicant to assemble and submit the missing information. An extension of the 30-day deadline shall be for no more than 30 days. The Board Office shall notify the applicant in writing of its decision to grant or deny the request for an extension. An applicant who requires an additional extension shall submit an additional written request in accordance with this subsection.
3. If an applicant fails to submit a complete application or registration form within the time allowed, the Board Office shall close the applicant's file. An applicant, whose file is closed and who later wishes to obtain a license, shall apply again in accordance with subsection (B).
4. From the date on which the administrative completeness review of an application or registration form is finished, the Board Office shall complete a substantive review of the applicant's qualifications in no more than 20 days.
   a. If an applicant is found to be ineligible, the Board Office shall issue a written notice of denial to the applicant.
   b. If an applicant is found to be eligible to take the NAPLEX, the Board Office shall issue a written notice of eligibility to the applicant and the NABP.
   c. If an applicant is found to be eligible to take the AZPLEX, the Board Office shall issue a written notice of eligibility to the applicant and the NABP.
   d. If the Board Office finds deficiencies during the substantive review of an application or registration form, the Board Office shall issue a written request to the applicant for additional documentation.
   e. The 20-day time-frame for a substantive review of eligibility to take the NAPLEX or AZPLEX is suspended from the date of a written request for additional documentation until the date that all documentation is received. The applicant shall submit the additional documentation in accordance with subsection (F)(2).
   f. If the applicant and the Board Office mutually agree in writing, the 20-day substantive review time-frame may be extended once for no more than 10 days.
5. For the purpose of A.R.S. § 41-1072 et.seq., the Board establishes the following time-frames for licensure by examination.
   a. Administrative completeness review time-frame: 20 days.

b. Substantive review time-frame: 20 days.
c. Overall time-frame: 40 days.

R4-23-203. Licensure by Reciprocity

A. Eligibility~~:~~. A person is eligible for licensure by reciprocity who:
1. Is licensed as a pharmacist in a jurisdiction that provides reciprocity to Arizona licensees;
2. Has passed the NABPLEX or NAPLEX with a score of 75 or better or was licensed by examination in another jurisdiction having essentially the same standards for licensure as Arizona at the time the pharmacist was licensed;
3. Provides evidence to the Board of having completed the required secondary and professional education and training;
4. Has engaged in the practice of pharmacy for at least ~~1~~ one year or has met the internship requirements of Arizona within the year immediately before the date of application; and
5. Has actively practiced as a pharmacist for 400 or more hours within the last calendar year. If this requirement is not met, an applicant may qualify for licensure by reciprocity by obtaining an Arizona graduate intern license and completing 400 hours of internship in an approved internship training site.

B. Application~~:~~.
1. ~~A person who is eligible and wishes to be licensed~~ An applicant for licensure by reciprocity shall file with the Board:
   a. ~~an application~~ A completed Application for Licensure by Reciprocity form ~~at least 20 days before the date of the AZPLEX~~ ; and
   b. A completed AZPLEX registration form.
2. The Board Office shall deem an application ~~for licensure by reciprocity~~ or registration form received on the date that the Board Office stamps on the application or registration form as the form is delivered to the Board Office.
3. An applicant for licensure by reciprocity shall:
   a. Make application ~~for licensure by reciprocity~~ on a form furnished by the Board, and
   b. ~~shall~~ Submit with the ~~application~~ Application for Licensure by Reciprocity form~~,~~:
      i. The documents specified in the application form, and
      ii. The reciprocity and examination fee specified in R4-23-205(B) and (C)~~. The fee shall be paid~~ and made payable to the Arizona State Board of Pharmacy by money order or certified or personal check ~~and entitles the applicant to 1 sitting of the AZPLEX~~.
4. An applicant for licensure by reciprocity shall:
   a. Make AZPLEX registration on a form furnished by the Board or NABP; and
   b. Submit with the registration form:
      i. The documents specified in the registration form; and
      ii. The examination fee specified by and made payable to NABP by money order, certified check, or bank draft.

~~4.~~5. The Board shall deem an ~~application for licensure by reciprocity~~ Application for Licensure by Reciprocity form or AZPLEX registration invalid after 12 months from the date the Board Office determines an application or registration form is complete. An applicant whose application or registration form is invalid and who wishes to continue licensure procedures, shall submit a new application or registration form and fee.

C. Passing grade; notification; re-examination~~:~~.
1. To pass the required examination, an applicant shall obtain a score of at least 75~~%~~ on the AZPLEX.
2. The Board Office shall:
   a. Retrieve an applicant's AZPLEX score from the NABP online database no later than two weeks after the applicant's examination date; and
   b. ~~mail~~ Mail an applicant's AZPLEX score to the applicant no later than ~~14~~ seven days after the ~~applicant takes the examination~~ Board Office receives the applicant's score from NABP.
3. ~~If~~ An applicant who fails the AZPLEX~~, the applicant~~ may apply ~~for reexamination~~ to retake an examination within the 12-month-application period defined in subsection ~~(B)(4)~~ (B)(5) of this Section. An applicant applying ~~for reexamination~~ to retake an examination shall submit to the Board Office a ~~written request to retake the AZPLEX including the examination date preferred by the applicant~~ completed AZPLEX registration form and pay the examination fee specified ~~in R4-23-205(C)(1)(b). The fee shall be paid to the Arizona State Board of Pharmacy by money order or certified or personal check~~ by and made payable to NABP by money order, certified check, or bank draft. An applicant who fails the AZPLEX ~~3~~ three times shall petition the Board for permission before retaking the examination.

D. Licensure~~:~~. The Board shall issue a certificate of licensure to a successful applicant upon receipt of the licensure fee specified in R4-23-205(A)(1)(a). The Board Office shall:
1. Provide a receipt for payment of the licensure fee to an applicant who delivers a payment in person; or
2. ~~mail~~ Mail a receipt for payment of the licensure fee to an applicant within ~~1~~ one working day of receiving the payment by mail or other delivery service.

E. Time-frames for licensure by reciprocity~~:~~. The Board Office shall follow the time-frames established for licensure by examination in R4-23-202(F).

R4-23-204. Continuing education requirements

A. General~~:~~. In accordance with A.R.S. § 32-1925(G), no renewal of license shall be issued by the Board unless the applicant has, during the two years preceding the application for renewal, participated in 30 contact hours (3.0 CEU's) of continuing education ~~activities~~ activity sponsored by an Approved Provider as defined in ~~(B)(5) of this section~~ R4-23-110, at least three contact hours (0.3 CEU's) of which shall be approved courses ~~on~~ in pharmacy law. ~~Pharmacists~~ A pharmacist licensed for less than 24 months shall accrue continuing education units determined by multiplying 1.25 hours times the number of months between the initial date of ~~their~~ licensure and the next license renewal date ~~of their application for renewal of their license~~.

~~**B.** Definitions:~~

~~1. Continuing education shall include study in the general areas of socio-economic and legal aspects of health care; the properties and actions of drugs and dosage forms; etiology, characteristics and therapeutics of disease status; and pharmacy practice.~~

~~2. Continuing education activities shall consist of institutes, seminars, lectures, conferences, workshops, various forms of mediated instruction, or programmed learning courses. Postgraduate studies in an accredited college of pharmacy shall be considered as continuing education activities.~~

~~3. A continuing education unit (CEU) is equivalent to ten contact hours of participation in a continuing education activity sponsored by an Approved Provider.~~

~~4. A contact hour is equivalent to 50 minutes of participation in a continuing education activity sponsored by an Approved Provider.~~

~~5. "Approved Provider" means an individual, institution, organization, association, corporation or agency that has been approved by the American Council on Pharmaceutical Education (A.C.P.E.) in accordance with its policy and procedures, or by the Board as having met criteria indicative of the ability to provide quality continuing education.~~

~~6. Mediated instruction refers to learning transmitted via intermediate mechanisms such as audio and/or visual tape, telephonic transmission, etc.~~

~~7. "Approved course in pharmacy law" means a continuing education activity that addresses practice issues related to state or federal pharmacy statutes, rules or regulations.~~

~~**C.**~~**B.** Acceptance of continuing education units (CEU's). ~~1.~~ The Board shall:

1. Only accept ~~continuing education units (~~CEU's~~)~~ for continuing education activities ~~provided the activities are~~ sponsored by an Approved Provider~~.~~;
2. Only accept ~~continuing education units (~~CEU's~~)~~ accrued during the two-year period immediately ~~prior to~~ before ~~renewal shall be considered acceptable for~~ licensure renewal~~.~~;
3. ~~No continuing education units (CEU's) may be~~ Not allow CEU's accrued in a biennial renewal period in ~~as~~ excess of the 3.0 CEU's required ~~and~~ to be carried forward to the succeeding biennial renewal period~~.~~;
4. ~~Any~~ Allow a pharmacist who leads, instructs, or lectures to groups of health professionals on pharmacy-related topics in continuing education activities sponsored by an Approved Provider ~~shall be granted continuing education units (CEU's) for such time expended during actual presentation, upon documentation to the Board~~ to receive CEU's for a presentation by following the same attendance procedures as any other attender of the continuing education activity~~.~~;
5. ~~Any pharmacist whose primary responsibility is the education of health professionals shall~~ Not ~~be granted continuing education units (CEU's) for~~ accept as CEU's the performance of normal teaching duties within ~~the~~ a learning institution~~.~~ by a pharmacist whose primary responsibility is the education of health professionals.

~~**D.**~~**C.** Continuing education records ~~of continuing education units (~~and reporting CEU's~~)~~:. ~~1.~~ Each individual pharmacist ~~is responsible for~~ shall:

1. ~~maintaining and preserving~~ Maintain continuing education records that:
   a. ~~which~~ Verify the continuing education activities ~~in which he or she has~~ the pharmacist participated in during the preceding five years~~.~~; and
2. ~~2.~~ b. ~~The records shall~~ Consist of ~~the~~ a certificate issued by ~~the~~ an Approved Provider at the conclusion of ~~each~~ a continuing education activity; ~~or documentation in the case of a leader, instructor or lecturer.~~

~~**E.** Reporting of continuing education units (CEU's):~~

~~1.~~2. At the time ~~a pharmacist is required to renew his or her license the pharmacist shall~~ of licensure renewal, attest to ~~participating in continuing education, pursuant to (A) of this section,~~ the number of CEU's the pharmacist participated in during the renewal period on the biennial renewal ~~application~~ form~~.~~; and

~~2.~~3. ~~In the event a pharmacist is~~ When requested by the Board ~~office to~~ Office, submit proof of continuing education participation ~~and fails to do so~~ within 20 days of the request~~, the licensee shall be advised he or she is non-compliant and shall be required to appear before the Board~~.

E. The license of a pharmacist who fails to comply with continuing education participation, recording, or reporting requirements of this Section may be revoked, suspended, or placed on probation.

F. ~~In the event that~~ A pharmacist who is aggrieved by any decision of the Board or its administrative staff concerning continuing education units~~, he~~ may request a hearing before the Board.

R4-23-205. Fees

A. Licensure fees:
1. Pharmacist:
   a. Initial licensure (Prorated according to A.R.S. § 32-1925(B)): ~~$110~~ 145.
   b. Licensure renewal: ~~$110~~ 145.
2. Pharmacy or graduate intern: $10.

B. Reciprocity fee: $300.

C. Examination ~~fee~~s: $50.
~~1. AZPLEX:~~
   ~~a. Initial: $100.~~
   ~~b. Retake: $50.~~
~~2. NAPLEX: specified by and made payable to NABP according to R4-23-202(B)(4).~~

D. Vendor permit fees (Resident and nonresident):
1. Pharmacy: ~~$300~~ 400 biennially. (Including hospital, and limited service.)
2. Drug wholesaler or manufacturer:
   a. Manufacturer: $1000 biennially.
   b. Full service drug wholesaler: $1000 biennially.
   c. Nonprescription drug wholesaler: $500 biennially.
3. Drug packager or repackager: $1000 biennially.
4. Nonprescription drug, retail:
   a. Category I (30 or fewer items): $100 biennially
   b. Category II (more than 30 items): $200 biennially
5. Compressed medical gas distributor: $200 biennially
6. Compressed medical gas supplier: $100 biennially

E. Other Fees:
1. Wall certificate.
   a. Pharmacist: $20.
   b. Pharmacy intern: $10.
   c. Relief Pharmacist: $10.
2. Duplicate of any Board-issued license, registration, certificate, or permit: $10.
3. Certification of electronic security system: $25.

F. Fees are not refunded under any circumstances except for the Board's failure to comply with its established licensure or permit time-frames under A.R.S. § 41-1077.

G. Penalty fee. Renewals submitted after expiration date are subject to penalty fees as provided in A.R.S. § 32-1925.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-22-101	Amend
R9-22-120	New Section
R9-22-2001	New Section
R9-22-2002	New Section
R9-22-2003	New Section
R9-22-2004	New Section
R9-22-2005	New Section
R9-22-2006	New Section
R9-22-2007	New Section
R9-22-2008	New Section
R9-22-2009	New Section
R9-22-2010	New Section
R9-22-2011	New Section

R9-22-2012	New Section
R9-22-2013	New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: A.R.S. § 36-2901.03

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening; 7 A.A.R. 2525, June 15, 2001

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

Proposed rule language will be available on the AHCCCS website (www.ahcccs.state.az.us) on August 20, 2001. Please send written comments to the above address by 5:00 p.m. October 2, 2001. Electronic transmission (E-mail) will not be accepted.

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The proposed rules contain requirements for the breast and cervical cancer treatment program that the Arizona Health Care Cost Containment System is required to implement under Laws 2001, Chapter 332 (HB 2194).

6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

Beginning January 1, 2002, the Arizona State Legislature appropriated $1.3 million in FY 2001-2002 and $1.4 million in FY 2002-2003 to AHCCCS from the state general fund for coverage of breast and cervical cancer treatment services for women who:

• Are screened for breast and cervical cancer through the WWHP after April 1, 2001;

• Are under 65 years of age;

• Are ineligible for Title XIX under Title 9, Chapter 22, Articles 14 and 15;

• Receive a positive screen, a confirmed diagnosis, and need a course of treatment for breast, cervical, or pre-cancerous cervical lesions as specified in R9-22-2002;

• Are not covered under creditable coverage as defined in Section 2701(c) of the Public Health Services Act (42 United States Code, Section 300gg(c); and

• Meet the requirements in R9-22-1402.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Proposed rule language will be available on the AHCCCS website (www.ahcccs.state.az.us) on August 20, 2001. Please send written comments to the above address by 5:00 p.m. October 2, 2001.Electronic transmission (E-mail) will not be accepted.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: October 2, 2001

Time: 9:00 a.m.

Location: AHCCCS
701 E. Jefferson, Gold Room
Phoenix, AZ 85034

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location: Yuma City Hall, City Council Chambers
180 W. 1st. St.
Yuma, AZ 85364

Parking: Parking is next door at the Armory.

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location: ALTCS: Arizona Long Term Care System
484 East Wilcox Drive
Sierra Vista, AZ 85635

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location: ALTCS: Arizona Long Term Care System
110 S. Church, Suite 325
Tucson, AZ 85701

Nature: Video Conference Oral Proceeding

Date: October 2, 2001

Time: 9:00 a.m.

Location: ALTCS: Arizona Long Term Care System
3480 E. Route 66
Flagstaff, AZ 86004

Nature: Video Conference Oral Proceeding

The Administration shall accept written comments until 5:00 p.m., Tuesday, October 2, 2001. Please submit comments at the public hearing listed above or to the following person:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions
R9-22-118. Reserved
R9-22-119. Reserved
R9-22-120. Breast and Cervical Cancer Treatment Program Related Definitions

ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM

Section
R9-22-2001. General Requirements
R9-22-2002. Course of Treatment
R9-22-2003. Eligibility Criteria
R9-22-2004. Application Process
R9-22-2005. Date of Application
R9-22-2006. Responsibility of A Woman Who Is Applying or Who Is a Member
R9-22-2007. Responsibility of WWHP Staff During the Initial Interview
R9-22-2008. Withdrawal of An Application
R9-22-2009. Approval Denial and Discontinuance of Eligibility
R9-22-2010. Effective Date of Eligibility
R9-22-2011. Redetermination of Eligibility
R9-22-2012. Enrollment
R9-22-2013. Grievance and Request for Hearing

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	**Section or Citation**
"210"	R9-22-114
"1931"	R9-22-114
"1-time income"	R9-22-116
"1st-party liability"	R9-22-110
"3-month income period"	R9-22-116
"3rd-party"	R9-22-110
"3rd-party liability"	R9-22-110
"Accommodation"	R9-22-107

"Act"	R9-22-114
"Acute mental health services"	R9-22-112
"Adequate notice"	R9-22-114
"ADHS"	R9-22-112
"Adjuvant"	R9-22-120
"Administration"	A.R.S. § 36-2901
"Administrative law judge"	R9-22-108
"Administrative review"	R9-22-108
"Adverse action"	R9-22-114
"AEC"	R9-22-117
"Affiliate corporate organization"	R9-22-106
"Aged"	42 U.S.C. 1382c(a)(1)(A)
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
"AHCCCS-disqualified dependent"	R9-22-101
"AHCCCS-disqualified spouse"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-107
"Ambulance"	R9-22-102
"Ancillary department"	R9-22-107
"Annual enrollment choice"	R9-22-117
"Appellant"	R9-22-114
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assignment"	R9-22-101
"Assistance unit"	R9-22-114
"Authorized representative"	R9-22-114
"Auto-assignment algorithm"	R9-22-117
"Baby Arizona"	R9-22-114
"Behavior management services"	R9-22-112
"Behavioral health paraprofessional"	R9-22-112
"Behavioral health professional"	R9-22-112
"Behavioral health service"	R9-22-112
"Behavioral health technician"	R9-22-112
"BHS"	R9-22-114
"Billed charges"	R9-22-107
"Blind"	R9-22-115
"Board-eligible for psychiatry"	R9-22-112
"Bona fide funeral agreement"	R9-22-114
"Burial plot"	R9-22-114
"Capital costs"	R9-22-107
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-114
"Case management services"	R9-22-112
"Case record"	R9-22-101
"Cash assistance"	R9-22-114
"Categorically-eligible"	A.R.S. §§ 36-2901 and 36-2934
"Certification"	R9-22-109
"Certification error"	R9-22-109
"Certification period"	R9-22-115 and R9-22-116
"Certified psychiatric nurse practitioner"	R9-22-112
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-112
"CMDP"	R9-22-117
"Complainant"	R9-22-108
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contractor"	R9-22-101
"Contractor of record"	R9-22-101
"Copayment"	R9-22-107

"Corrective action plan"	R9-22-109
"Cost-to-charge ratio"	R9-22-107
"Countable income"	R9-22-116
"County eligibility department"	R9-22-109
"County eligibility staff"	R9-22-116
"Covered charges"	R9-22-107
"Covered services"	R9-22-102
"CPT"	R9-22-107
"CRS"	R9-22-114
"Cryotherapy"	R9-22-120
"Date of determination"	R9-22-116
"Date of enrollment action"	R9-22-117
"Date of notice"	R9-22-108
"Day"	R9-22-101
"DCSE"	R9-22-114
"Deductible medical expense"	R9-22-116
"Deemed application date"	R9-22-116
"De novo hearing"	R9-22-112
"Dentures"	R9-22-102
"Department"	R9-22-114
"Dependent child"	R9-22-114 and R9-22-116
"DES"	R9-22-101
"Determination"	R9-22-116
"Diagnostic services"	R9-22-102
"Director"	R9-22-101
"Disabled"	R9-22-115
"Discontinuance"	R9-22-116
"Discussions"	R9-22-106
"Disenrollment"	R9-22-117
"District Medical Consultant"	R9-22-114
"DME"	R9-22-102
"DRI inflation factor"	R9-22-107
"E.P.S.D.T. services"	R9-22-102
"EAC"	R9-22-101
"Earned income"	R9-22-116
"Educational income"	R9-22-116
"ELIC"	R9-22-101
"Eligible person"	A.R.S. § 36-2901
"Emancipated minor"	R9-22-116
"Emergency medical condition"	42 U.S.C. 1396b(v)
"Emergency medical services"	R9-22-102
"Encounter"	R9-22-107
"Enrollment"	R9-22-117
"Enumeration"	R9-22-101
"Equity"	R9-22-101
"Evaluation"	R9-22-112
"Expressly emancipated minor"	R9-22-116
"FAA"	R9-22-114
"Facility"	R9-22-101
"Factor"	R9-22-101
"FBR"	R9-22-101
"FESP"	R9-22-101
"Foster care maintenance payment"	41 U.S.C. 675(4)(A)
"FPL"	R9-22-114
"QHC"	R9-22-101
"Fraudulent information"	R9-22-109
"Grievance"	R9-22-108
"GSA"	R9-22-101
"Guardian"	R9-22-116

"Head-of-household"	R9-22-116
"Hearing"	R9-22-108
"Hearing aid"	R9-22-102
"Home health services"	R9-22-102
"Homebound"	R9-22-114
"Hospital"	R9-22-101
"Hospitalized"	R9-22-116
"ICU"	R9-22-107
"IHS"	R9-22-117
"IMD"	R9-22-112
"Income"	R9-22-114 and R9-22-116
"Income-in-kind"	R9-22-116
"Indigent"	A.R.S. § 11-297
"Inmate of a public institution"	42 CFR 435.1009
"Inpatient psychiatric facilities for persons under age 21"	R9-22-112
"Interested party"	R9-22-106
"Interim change"	R9-22-116
"JTPA"	R9-22-114
"LEEP"	R9-22-120
"License" or "licensure"	R9-22-101
"Liquid assets"	R9-22-116
"Liquid resources"	R9-22-116
"Lump-sum income"	R9-22-116
"Mailing date"	R9-22-114
"Medical education costs"	R9-22-107
"Medical record"	R9-22-101
"Medical review"	R9-22-107
"Medical services"	R9-22-101
"Medical supplies"	R9-22-102
"Medical support"	R9-22-114
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-107
"Medicare HMO"	R9-22-101
"Member"	R9-22-101
"Mental disorder"	R9-22-112
"MI/MN"	A.R.S. § 36-2901(4)(a) and (c)
"Minor parent"	R9-22-114
"Month of determination"	R9-22-116
"New hospital"	R9-22-107
"NF"	R9-22-101
"NICU"	R9-22-107
"Noncontracting provider"	A.R.S. § 36-2931
"Nonliquid resources"	R9-22-116
"Nonparent caretaker relative"	R9-22-114
"OAH"	R9-22-108
"Occupational therapy"	R9-22-102
"Offeror"	R9-22-106
"Operating costs"	R9-22-107
"Outlier"	R9-22-107
"Outpatient hospital service"	R9-22-107
"Ownership change"	R9-22-107
"Partial Care"	R9-22-112
"Party"	R9-22-108
"Peer group"	R9-22-107
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	R9-22-102
"Post-stabilization services"	42 CFR 438.114

"Practitioner"	R9-22-102
"Pre-enrollment process"	R9-22-114
"Prescription"	R9-22-102
"Primary care provider"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Private duty nursing services"	R9-22-102
"Proposal"	R9-22-106
"Prospective rates"	R9-22-107
"Prospective rate year"	R9-22-107
"Prudent layperson standard"	42 U.S.C. 1396u-2
"Psychiatrist"	R9-22-112
"Psychologist"	R9-22-112
"Psychosocial rehabilitation"	R9-22-112
"Public assistance"	R9-22-116
"Quality control case analysis"	R9-22-109
"Quality control sample review"	R9-22-109
"Quality management"	R9-22-105
"Radiology services"	R9-22-102
"RBHA"	R9-22-112
"Rebasing"	R9-22-107
"Recipient"	R9-22-114
"Redetermination"	R9-22-116
"Referral"	R9-22-101
"Rehabilitation services"	R9-22-102
"Reinsurance"	R9-22-107
"Resources"	R9-22-114 and R9-22-116
"Respiratory therapy"	R9-22-102
"Respondent"	R9-22-108
"Responsible offeror"	R9-22-106
"Responsive offeror"	R9-22-106
"Review"	R9-22-114
"RFP"	R9-22-106
"Scope of services"	R9-22-102
"Screening"	R9-22-112
"SDAD"	R9-22-107
"Separate property"	A.R.S. § 25-213
"Service location"	R9-22-101
"Service site"	R9-22-101
"SESP"	R9-22-101
"S.O.B.R.A."	R9-22-101
"Specialist"	R9-22-102
"Specified relative"	R9-22-114 and R9-22-116
"Speech therapy"	R9-22-102
"Spendthrift restriction"	R9-22-114
"Spouse"	R9-22-101
"SSA"	P.L. 103-296, Title I
"SSI"	R9-22-101
"SSN"	R9-22-101
"State alien"	R9-22-101
"Sterilization"	R9-22-102
"Subcontract"	R9-22-101
"Substance abuse"	R9-22-112
"SVES"	R9-22-114
"Tier"	R9-22-107
"Tiered per diem"	R9-22-107
"Title IV-A"	R9-22-114
"Title IV-D"	R9-22-114
"Title IV-E"	R9-22-114

"Title XIX"	42 U.S.C. 1396
"Title XXI"	42 U.S.C. 1397jj
"TMA"	R9-22-114
"Total inpatient hospital days"	R9-22-107
"Treatment"	R9-22-112
"Unearned income"	R9-22-116
"Utilization management"	R9-22-105
"WWHP"	R9-22-120

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS-disqualified dependent" means a dependent child of an AHCCCS-disqualified spouse who resides in the same household of an AHCCCS-disqualified spouse.

"AHCCCS-disqualified spouse" means the spouse of an MI/MN applicant, who is ineligible for MI/MN benefits because the value of that spouse's separate property, when combined with the value of other resources owned by household members, exceeds the allowable resource limit.

"Applicant" means a person who submits or whose representative submits, a written, signed, and dated application for AHCCCS benefits that has not been approved or denied.

"Application" means an official request for medical assistance made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific AHCCCS-covered service and equipment provided to a member. A ~~payments~~ payment is made in accordance with an upper, or capped, limit established by the Director.

"Case record" means the file and all documents in the file that are used to establish eligibility.

"Categorically-eligible" means a person who is eligible as defined by A.R.S. §§ 36-2901 and 36-2934.

"Continuous stay" means the period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and these rules.

"Contractor" means a person, an organization, or an entity that agrees, through a direct contracting relationship with the Administration, to provide goods and services specified by the contract under the requirements of the contract and these rules.

"Contractor of record" means an organization or an entity in which a person is enrolled for the provision of AHCCCS services.

"Day" means a calendar day unless otherwise specified in the text.

"Director" means the Director of the Administration or the Director's designee.

"DES" means the Department of Economic Security.

"EAC" means eligible assistance children defined by A.R.S. § 36-2905.03.

"ELIC" means eligible low-income children defined by A.R.S. § 36-2905.03.

"Eligible person" means the person defined in A.R.S. § 36-2901.

"Enumeration" means the assignment of a specific 9-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash or market value of a resource minus valid liens, encumbrances, or both.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution, under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related services.

"Factor" means an organization, a collection agency, a service bureau, or a person who advances money to a provider for accounts receivable that the provider assigns, sells, or otherwise transfers, including transfers through the use of a power of attorney, to the organization, the collection agency, the service bureau, or the person that receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. The term "factor"

does not include a business representative, such as a bailing agent or an accounting firm described within these rules, or a health care institution.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"FESP" means federal emergency services program that is designed to provide emergency medical services covered under 42 U.S.C. 1396b(v), to treat an emergency medical condition for a categorically-eligible member who is determined eligible under A.R.S. § 36-2903.03.

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor of record provides, directly or through a subcontract, a covered health care service to a member enrolled with that contractor of record.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of certification.

"Indigent" means meeting eligibility criteria under A.R.S. § 11-297.

"Inmate of a public institution" means a person defined by 42 CFR 435.1009.

"License" or "licensure" means a nontransferable authorization that is based on established standards in law, is issued by a state or a county regulatory agency or board, and allows a health care provider to render a health care service lawfully.

"Medical record" means all documents that relate to medical and behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that are kept at the site of the provider.

"Medical services" means health care services provided to a member by a physician, a practitioner, a dentist, or by a health professional and technical personnel under the direction of a physician, a practitioner, or a dentist.

"Medically necessary" means a covered service provided by a physician or other licensed practitioner of the healing arts and within the scope of practice under state law to:

Prevent disease, disability, and other adverse health conditions or their progression; or

Prolong life.

"Medicare HMO" means a health maintenance organization that has a current contract with the Health Care Financing Administration (HCFA) for participation in the Medicare program under 42 CFR 417(L).

"Member" is defined in A.R.S. § 36-2901.

"MI/MN" means medically indigent and medically needy defined in A.R.S. § 36-2901(4)(a) and (c).

"NF" means a nursing facility defined in 42 U.S.C. 1396r(a).

"Noncontracting provider" means the provider defined in A.R.S. § 36-2931.

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Separate property" means property defined in A.R.S. § 25-213.

"Service location" means any location at which a member obtains any health care service provided by a contractor of record under the terms of a contract.

"Service site" means a location designated by a contractor of record as the location at which a member is to receive health care services.

"SESP" means state emergency services program that is designed to provide emergency medical services identified as covered under R9-22-217 to treat an emergency medical condition for a person who is determined eligible under A.R.S. § 36-2905.05.

"S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(ii)(IX), July 1, 1988.

"Spouse" means the husband or wife who has entered into a contract of marriage, recognized as valid by Arizona.

"SSA" means Social Security Administration defined in P.L. 103-296, Title I.

"SSI" means Supplemental Security Income under Title XVI of the Social Security Act, as amended.

"SSN" means social security number.

"State alien" means an nonqualified alien under A.R.S. § 36-2903.03 who:

Was residing in the United States under color of law on or before August 21, 1996;

Was receiving AHCCCS services under SSI eligibility criteria; and

Would be eligible for coverage under 9 A.A.C. 22, Article 15 except for United States citizenship or legal alienage requirements.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member;

A marketing organization; or

Any other organization or person who agrees to perform any administrative function or service for a contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

R9-22-118. Reserved

R9-22-119. Reserved

R9-22-120. Breast and Cervical Cancer Treatment Program Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meaning unless the context explicitly requires another meaning:

"Adjuvant" means a pharmacological agent added to a drug to enhance its effect, or an immunological agent that increases the antigenic response.

"Cryotherapy" means the treatment of abnormal tissue using extremely cold temperatures.

"LEEP" means the loop electrosurgical excision procedure that passes electrical current through a thin wire loop which acts as a knife.

"WWHP" means the Well Women Healthcheck Program administered by ADHS established under the authorization of the Breast and Cervical Mortality Prevention Act of 1990, Public Law 101-354.

ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM

R9-22-2001. General Requirements

A. Purpose. This Article defines the requirements and conditions for the Breast and Cervical Cancer Treatment Program under A.R.S. § 36-2901.03.

B. Effective date. The effective date of this Article is January 1, 2002.

C. Confidentiality. The Administration and ADHS shall maintain the confidentiality of a woman's records and shall not disclose a woman's financial, medical, or other confidential information except as allowed under R9-22-512.

D. Covered Services. A woman who is eligible under this Article receives all medically necessary services under Articles 2 and 12.

R9-22-2002. Course of Treatment

A. Breast Cancer. For purposes of this program a course of treatment for breast cancer shall conclude 12 months after the last encounter for specific therapy for the cancer. A course of treatment includes any one, combination or all of the following:

1. Lumpectomy or other breast surgery,
2. Chemotherapy,
3. Radiation therapy, or
4. Other peer reviewed treatments that are considered standard of care for this diagnosis as determined by the AHCCCS Chief Medical Officer.
5. Adjuvant therapy. Adjuvant therapy shall be considered standard of care and not investigational. Tamoxifen combined with another therapy shall be considered adjuvant therapy and shall be covered for a maximum of 12 months after the last encounter.

B. Pre-cancerous cervical lesions. For purposes of this program the course of treatment for pre-cancerous cervical lesions including moderate or severe cervical dysplasia or carcinoma in situ shall conclude four months after the last encounter for specific therapy for the pre-cancerous lesion. A course of treatment includes any one, combination or all of the following:

1. Conization procedure,
2. LEEP procedure,
3. Cryotherapy, or
4. Other peer reviewed treatments that are considered standard of care for this diagnosis as determined by the AHCCCS Chief Medical Officer.

C. Cervical Cancer. For purposes of this program the course of treatment for cervical cancer shall conclude 12 months after the last encounter for specific therapy for the cancer. A course of treatment includes any one, combination or all of the following:

1. Surgery,
2. Radiation therapy,

3. Chemotherapy,
4. Adjuvant therapy. Adjuvant therapy shall be considered standard of care and not investigational, or
5. Other peer reviewed treatments that are considered standard of care for this diagnosis as determined by the AHCCCS Chief Medical Officer.

R9-22-2003. Eligibility Criteria

A. Criteria. To be eligible for the Breast and Cervical Cancer Treatment Program under this Article, a woman shall meet the requirements of this Article and:
1. Be screened for breast and cervical cancer through the WWHP after April 1, 2001;
2. Be under 65 years of age;
3. Be ineligible for Title XIX under Articles 14 and 15;
4. Receive a positive screen, a confirmed diagnosis, and need a course of treatment for breast, cervical, or pre-cancerous cervical lesions as specified in R9-22-2002;
5. Not covered under creditable coverage as defined in Section 2701(c) of the Public Health Services Act (42 United States Code, Section 300gg(c)); and
6. Meet the requirements in R9-22-1402.

B. Ineligible Woman. A woman is not eligible for Breast and Cervical Cancer Treatment Program under this Article if the woman:
1. Is an inmate of a public institution if federal financial participation (FFP) is not available,
2. Is age 21 through age 64 and is residing in an Institution for Mental Disease as defined in 42 CFR 435.1009 except when allowed under the Administration's 1115 waiver with HCFA,
3. No longer meets an eligibility requirement of this Article, or
4. Does not require a course of treatment as specified in R9-22-2002.

C. Metastasized cancer. During an ongoing period of eligibility, if a metastasized cancer, that is a known or presumed complication of the breast or cervical cancer is found in another part of a woman's body, the woman's eligibility under this Article shall be extended to cover treatment of that cancer.

D. Reoccurrence of cancer. If additional breast or cervical cancer is found after a treatment period has ended and eligibility under this Article is ended, a woman shall be screened under the WWHP program before eligibility shall be established.

E. Ineligible Male. A male is precluded from receiving screening and diagnostic services under the WWHP program under Public Law 101-354 and is not eligible under this Article.

R9-22-2004. Application Process

A. Application. A woman may apply for eligibility under this Article by completing an application provided by the WWHP staff. A complete application contains all the information requested.

B. Obtaining the application. The application form is available at the WWHP locations.

C. Assistance with the application. The WWHP staff shall allow a person of the woman's choice to accompany, assist, and represent the woman in the application process.

D. Submitting the application. The woman may complete and submit the application at the time of the WWHP screening or the woman may mail the application directly to the Administration.

R9-22-2005. Date of Application

A woman's date of application is the date the WWHP staff receive positive diagnosis for breast cancer, cervical cancer or pre-cancerous lesions.

R9-22-2006. Responsibility of A Woman Who Is Applying or Who Is a Member

A woman who is applying or who is a member shall:
1. Give complete and truthful information on the application;
2. Comply with the requirements of this Article;
3. Provide verification of information, if requested;
4. Provide medical insurance information; and
5. Inform the Administration about changes in address, residence, and alienage status.

R9-22-2007. Responsibility of WWHP Staff During the Initial Interview

During the initial interview, WWHP staff shall:
1. Assist the woman completing the application, if requested;
2. Discuss and provide the woman with information explaining:
   a. The eligibility requirements,
   b. The requirement to provide a SSN,
   c. Consequences of failure-to-cooperate with R9-22-2006,
   d. Assignment of rights under operation of law,
   e. Enrollment, and

f. The right to request a hearing; and
3. Review the penalties for perjury and fraud.

R9-22-2008. Withdrawal of An Application

A woman may withdraw an application at any time before the WWHP staff completes an eligibility determination by making an oral or written request to WWHP for withdrawal and stating the reason for withdrawal.

R9-22-2009. Approval, Denial, and Discontinuance of Eligibility

A. Time-frame. The WWHP staff shall send a woman's application to the Administration within 24 hours from the date that the WWHP is notified by the WWHP provider that the woman has a positive diagnosis for breast cancer, cervical cancer or pre-cancerous lesions. The Administration shall determine eligibility under this Article within seven days of the receipt of the application.

B. Approval. If the woman under subsection (A) meets all the eligibility requirements in this Article, the Administration shall provide the woman with an approval notice. The approval notice shall contain:
1. The name of the eligible woman,
2. The effective date of eligibility, and
3. Information regarding the woman's appeal and request for hearing rights.

C. Denial. If a woman under subsection (A) fails to meet an eligibility requirement in this Article, the Administration shall deny the application and provide the woman with a denial notice. The denial notice shall contain:
1. The name of the ineligible woman,
2. The specific reason why the woman is ineligible,
3. The legal citations supporting the reason for the denial,
4. The location where the woman can review the legal citations, and
5. Information regarding the woman's appeal and request for hearing rights.

D. Discontinuance.
1. Except as specified in subsection (D)(2), if a woman no longer meets an eligibility requirement in this Article, the Administration shall provide the woman an advance Notice of Action no later than 10 days before the effective date of the discontinuance.
2. The Administration may mail an Notice of Adverse Action no later than the effective date of the discontinuance if the Administration:
   a. Receives a written statement from the woman to voluntary withdraw from AHCCCS,
   b. Receives information confirming the death of the woman,
   c. Receives returned mail with no forwarding address from the post office and the woman's whereabouts are unknown, or
   d. Receives information confirming that the member has been approved for Medicaid services outside the state of Arizona.
3. The Notice of Action shall contain:
   a. Name of the ineligible woman,
   b. Effective date of the discontinuance,
   c. Specific reason why the woman is discontinued,
   d. The legal citations supporting the reason for the discontinuance,
   e. The location where the woman can review the legal citations, and
   f. Information regarding the woman's appeal and request for hearing rights.

R9-22-2010. Effective Date of Eligibility

The effective date of eligibility is the first day of the month of application under R9-22-2005 or the first day of the first eligible month, whichever is later.

R9-22-2011. Redetermination of Eligibility

A. Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year. If a woman continues to meet the requirements of eligibility for the Breast and Cervical Cancer Treatment Program, the Administration shall notify the woman of continued eligibility. A woman is not required to be screened for breast and cervical cancer through the WWHP under R9-22-2003 at redetermination.

B. Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the woman's circumstances, including a change in course of treatment under R9-22-2002, which could affect eligibility.

R9-22-2012. Enrollment

Choice of health plan. A woman who is eligible under this Article is enrolled with a contractor under Article 17.

R9-22-2013. Grievance and Request for Hearing
A woman who applies, who is approved, denied, or discontinued for the Breast and Cervical Cancer Treatment Program under this Article may file a grievance or request a hearing under Article 8.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-22-101	Amend
Article 4	Repeal
R9-22-401	Repeal
R9-22-402	Repeal
R9-22-403	Repeal
R9-22-404	Repeal
R9-22-405	Repeal
R9-22-406	Repeal
Article 6	Amend
R9-22-601	Amend
R9-22-602	Repeal
R9-22-602	New Section
R9-22-603	Repeal
R9-22-603	New Section
R9-22-604	Amend
R9-22-605	New Section
R9-22-606	New Section
R9-22-701	Amend
R9-22-709	Amend
R9-22-714	Repeal
R9-22-714	New Section
R9-22-716	Amend
R9-22-719	New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2906

Implementing statute: A.R.S. §§ 36-2903, 36-2904, and 36-2906

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 3050, July 13, 2001

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

5. An explanation of the rule, including the agency's reasons for initiating the rule:

These rules define the contracts/RFP process for AHCCCS' acute care programs. The Administration is amending these rules to make the rules more clear, concise, and understandable and comply with the January 2002 G.R.R.C. deadline for the five-year review.

6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

The contractors, members, and the Arizona Health Care Cost Containment System Administration (AHCCCSA) will be nominally impacted by the changes to the rule language. The Administration is amending these rules to:

Increase clarity and conciseness,

Add performance measurement language in accordance with statute, and

Remove language that is more appropriate in contract.

There will be no fiscal impact on businesses or political subdivisions since the proposed rule language changes are nonsubstantive and are intended to streamline and clarify the existing rules. Articles 4 and 6 are combined to increase clarity and conciseness. Language that does not clearly present policies or procedures is clarified. Citations to documents incorporated in the rule are updated, as needed. The performance measurement language clarifies existing statutory authority. Duplicative language that appropriately exists in contract is deleted. There will be a minor impact for the cost of printing the copies for the rule, once adopted and approved.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: October 2, 2001

Time: 9:00 a.m.

Location: AHCCCS
701 E. Jefferson, Gold Room
Phoenix, AZ 85034

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location: Yuma City Hall, City Council Chambers
180 W. 1st. St.
Yuma, AZ 85364

Parking: Parking is next door at the Armory.

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location: ALTCS: Arizona Long Term Care System
484 E. Wilcox Drive
Sierra Vista, AZ 85635

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location: ALTCS: Arizona Long Term Care System
110 S. Church, Suite 3250
Tucson, AZ 85701

Nature: Video Conference Oral Proceeding

Date: October 2, 2001

Time: 9:00 a.m.

Location: ALTCS: Arizona Long Term Care System
3480 E. Route 66
Flagstaff, AZ 86004

Nature: Video Conference Oral Proceeding

The Administration shall accept written comments until 5:00 p.m., Tuesday, October 2, 2001. Please submit comments at the public hearing listed above or to the following person:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

Description	Date	Location
42 U.S.C. 1396u-2(d)(3)	August 5, 1997	R9-22-601(B)
42 CFR 455.101	September 30, 1986	R9-22-602(B)(5)

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

ARTICLE 1. DEFINITIONS

ARTICLE 4. ~~CONTRACTS, ADMINISTRATION, AND STANDARDS~~ REPEALED

ARTICLE 6. ~~REQUEST FOR PROPOSALS (RFP)~~ RFP AND CONTRACT PROCESS

ARTICLE 7. STANDARDS FOR PAYMENTS

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
"210"	R9-22-114
"1931"	R9-22-114
"1-time income"	R9-22-116
"1st-party liability"	R9-22-110
"3-month income period"	R9-22-116
"3rd-party"	R9-22-110
"3rd-party liability"	R9-22-110
"Accommodation"	R9-22-107
"Act"	R9-22-114
"Acute mental health services"	R9-22-112
"Adequate notice"	R9-22-114
"ADHS"	R9-22-112
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-22-114
"AEC"	R9-22-117
"Affiliate corporate organization"	R9-22-106
"Aged"	42 U.S.C. 1382c(a)(1)(A)
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
"AHCCCS-disqualified dependent"	R9-22-101
"AHCCCS-disqualified spouse"	R9-22-101
"AHCCCS hearing officer"	R9-22-108

"AHCCCS inpatient hospital day or days of care"	R9-22-107
"Ambulance"	R9-22-102
"Ancillary department"	R9-22-107
"Annual enrollment choice"	R9-22-117
"Appeal"	R9-22-108
"Appellant"	R9-22-114
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assignment"	R9-22-101
"Assistance unit"	R9-22-114
"Authorized representative"	R9-22-114
"Auto-assignment algorithm"	R9-22-117
"Baby Arizona"	R9-22-114
"Behavior management services"	R9-22-112
"Behavioral health paraprofessional"	R9-22-112
"Behavioral health professional"	R9-22-112
"Behavioral health service"	R9-22-112
"Behavioral health technician"	R9-22-112
"BHS"	R9-22-114
"Billed charges"	R9-22-107
"Blind"	R9-22-115
"Board-eligible for psychiatry"	R9-22-112
"Bona fide funeral agreement"	R9-22-114
"Burial plot"	R9-22-114
"Capital costs"	R9-22-107
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-114
"Case management services"	R9-22-112
"Case record"	R9-22-101
"Cash assistance"	R9-22-114
"Categorically eligible"	A.R.S. §§ 36-2901 and 36-2934
"Certification"	R9-22-109
"Certification error"	R9-22-109
"Certification period"	R9-22-115 and R9-22-116
"Certified psychiatric nurse practitioner"	R9-22-112
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-112
"CMDP"	R9-22-117
"Continuous stay"	R9-22-101
"Contractor"	R9-22-101
"Contractor of record"	R9-22-101
"Copayment"	R9-22-107
"Corrective action plan"	R9-22-109
"Cost-to-charge ratio"	R9-22-107
"Countable income"	R9-22-116
"County eligibility department"	R9-22-109
"County eligibility staff"	R9-22-116
"Covered charges"	R9-22-107
"Covered services"	R9-22-102
"CPT"	R9-22-107
"CRS"	R9-22-114
"Date of determination"	R9-22-116
"Date of enrollment action"	R9-22-117
"Day"	R9-22-101
"DCSE"	R9-22-114
"Deductible medical expense"	R9-22-116
"Deemed application date"	R9-22-116
"De novo hearing"	R9-22-112

"Dentures"	R9-22-102
"Department"	R9-22-114
"Dependent child"	R9-22-114 and R9-22-116
"DES"	R9-22-101
"Determination"	R9-22-116
"Diagnostic services"	R9-22-102
"Disabled"	R9-22-115
"Discontinuance"	R9-22-116
"Discussions"	R9-22-106
"Disenrollment"	R9-22-117
"District Medical Consultant"	R9-22-114
"DME"	R9-22-102
"DRI inflation factor"	R9-22-107
"E.P.S.D.T. services"	R9-22-102
"EAC"	R9-22-101
"Earned income"	R9-22-116
"Educational income"	R9-22-116
"ELIC"	R9-22-101
"Eligible person"	A.R.S. § 36-2901
"Emancipated minor"	R9-22-116
"Emergency medical condition"	42 U.S.C. 1396b(v)
"Emergency medical services"	R9-22-102
"Encounter"	R9-22-107
"Enrollment"	R9-22-117
"Enumeration"	R9-22-101
"Equity"	R9-22-101
"Evaluation"	R9-22-112
"Expressly emancipated minor"	R9-22-116
"FAA"	R9-22-114
"Facility"	R9-22-101
"Factor"	R9-22-101
"FBR"	R9-22-101
"FESP"	R9-22-101
"Foster care maintenance payment"	41 U.S.C. 675(4)(A)
"FPL"	R9-22-114
"FQHC"	R9-22-101
"Fraudulent information"	R9-22-109
"Grievance"	R9-22-108
"GSA"	R9-22-101
"Guardian"	R9-22-116
"Head-of-household"	R9-22-116
"Hearing aid"	R9-22-102
"Home health services"	R9-22-102
"Homebound"	R9-22-114
"Hospital"	R9-22-101
"Hospitalized"	R9-22-116
"ICU"	R9-22-107
"IHS"	R9-22-117
"IMD"	R9-22-112
"Income"	R9-22-114 and R9-22-116
"Income-in-kind"	R9-22-116
"Indigent"	A.R.S. § 11-297
"Inmate of a public institution"	42 CFR 435.1009
"Inpatient psychiatric facilities for persons under age 21"	R9-22-112
"Interested party"	R9-22-106
"Interim change"	R9-22-116
"JTPA"	R9-22-114
"License" or "licensure"	R9-22-101

"Liquid assets"	R9-22-116
"Liquid resources"	R9-22-116
"Lump-sum income"	R9-22-116
"Mailing date"	R9-22-114
"Medical education costs"	R9-22-107
"Medical record"	R9-22-101
"Medical review"	R9-22-107
"Medical services"	R9-22-101
"Medical supplies"	R9-22-102
"Medical support"	R9-22-114
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-107
"Medicare HMO"	R9-22-101
"Member"	R9-22-101
"Mental disorder"	R9-22-112
"MI/MN"	A.R.S. § 36-2901(4)(a) and (c)
"Minor parent"	R9-22-114
"Month of determination"	R9-22-116
"New hospital"	R9-22-107
"NF"	R9-22-101
"NICU"	R9-22-107
"Noncontracting provider"	A.R.S. § 36-2931
"Nonliquid resources"	R9-22-116
"Nonparent caretaker relative"	R9-22-114
"Occupational therapy"	R9-22-102
"Offeror"	R9-22-106
"Operating costs"	R9-22-107
"Outlier"	R9-22-107
"Outpatient hospital service"	R9-22-107
"Ownership change"	R9-22-107
"Partial Care"	R9-22-112
"Peer group"	R9-22-107
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	R9-22-102
"Post-stabilization services"	42 CFR 438.114
"PPC"	R9-22-107
"Practitioner"	R9-22-102
"Pre-enrollment process"	R9-22-114
"Prescription"	R9-22-102
"Primary care provider"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Private duty nursing services"	R9-22-102
"Proposal"	R9-22-106
"Prospective rates	R9-22-107
"Prospective rate year"	R9-22-107
"Prudent layperson standard"	42 U.S.C. 1396u-2
"Psychiatrist"	R9-22-112
"Psychologist"	R9-22-112
"Psychosocial rehabilitation"	R9-22-112
"Public assistance"	R9-22-116
"Quality control case analysis"	R9-22-109
"Quality control sample review"	R9-22-109
"Quality management"	R9-22-105
"Radiology services"	R9-22-102
"RBHA"	R9-22-112
"Rebasing"	R9-22-107
"Recipient"	R9-22-114

"Redetermination"	R9-22-116
"Referral"	R9-22-101
"Rehabilitation services"	R9-22-102
"Reinsurance"	R9-22-107
"Resources"	R9-22-114 and R9-22-116
"Respiratory therapy"	R9-22-102
"Responsible offeror"	R9-22-106
"Responsive offeror"	R9-22-106
"Review"	R9-22-114
"RFP"	R9-22-106
"Scope of services"	R9-22-102
"Screening"	R9-22-112
"SDAD"	R9-22-107
"Separate property"	A.R.S. § 25-213
"Service location"	R9-22-101
"Service site"	R9-22-101
"SESP"	R9-22-101
"S.O.B.R.A."	R9-22-101
"Specialist"	R9-22-102
"Specified relative"	R9-22-114 and R9-22-116
"Speech therapy"	R9-22-102
"Spendthrift restriction"	R9-22-114
"Spouse"	R9-22-101
"SSA"	P.L. 103-296, Title I
"SSI"	R9-22-101
"SSN"	R9-22-101
"State alien"	R9-22-101
"Sterilization"	R9-22-102
"Subcontract"	R9-22-101
"Substance abuse"	R9-22-112
"SVES"	R9-22-114
"Tier"	R9-22-107
"Tiered per diem"	R9-22-107
"Title IV-A"	R9-22-114
"Title IV-D"	R9-22-114
"Title IV-E"	R9-22-114
"Title XIX"	42 U.S.C. 1396
"Title XXI"	42 U.S.C. 1397jj
"TMA"	R9-22-114
"Total inpatient hospital days"	R9-22-107
"Treatment"	R9-22-112
"Unearned income"	R9-22-116
"Utilization management"	R9-22-105

R9-22-107. Standard for Payments Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

~~1.~~ "Accommodation" means the bed and board services provided to a patient during an inpatient hospital stay and includes the cost of all staffing, supplies, and equipment. The accommodation is typically semi-private except when the member must be isolated for medical reasons. Other types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which bed and board are provided.

~~2.~~ "Aggregate" means the combined amount of hospital payments for covered services provided within and outside the service area.

~~3.~~ "AHCCCS inpatient hospital day or days of care" means the period of time beginning with the day of admission and includes each day of an inpatient stay for an eligible person, including the day of death, but excluding the day of discharge, provided that all medical necessity and medical review requirements are met.

~~4.~~ "Ancillary department" means the department of a hospital that provides ancillary services and outpatient services, which are defined in the Medicare Provider Reimbursement Manual.

~~5.~~ "Billed charges" means charges that a hospital includes on a claim for providing hospital services to an eligible person or member consistent with the rates and charges filed by the hospital with the Arizona Department of Health Services.
~~6.~~ "Capital costs" means capital-related costs, which are defined in the Medicare Provider Reimbursement Manual, Chapter 28, such as building and fixtures, and movable equipment.
~~7.~~ "Clean claim" has the meaning in A.R.S. § 36-2904.
~~8.~~ "Copayment" means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.
~~9.~~ "Cost-to-charge ratio" means a hospital's costs for providing covered services divided by the hospital's covered charges for the same services.
~~10.~~ "Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for AHCCCS-covered services that meet medical review criteria of the Administration or contractor.
~~11.~~ "CPT" means current procedural terminology, the manual published and updated by the American Medical Association, which is a nationally accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and provides a uniform language that will accurately designate medical, surgical, and diagnostic services.
~~12.~~ "DRI inflation factor" means the Data Resources Inc., Health Care Financing Administration-type hospital input price index for prospective hospital reimbursement, which is published by DRI/McGraw-Hill.
~~13.~~ "Encounter" means a record of medical service, submitted by a contractor and processed by AHCCCS, that is rendered by a provider registered with AHCCCS to a member who is enrolled with the contractor on the date of service, and for which the contractor incurs any financial liability.
~~14.~~ "ICU" means the intensive care unit of a hospital.
~~15.~~ "Medical education costs" means direct hospital costs for intern and resident salaries, fringes, and program costs, nursing school education, and paramedical education, which is defined in the Medicare Provider Reimbursement Manual, Chapter 28.
~~16.~~ "Medical review" means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that services provided to an eligible person or member are medically necessary and covered services and that required authorizations are obtained by the provider. The criteria for medical review are established by the Administration or contractor based on medical practice standards that are updated periodically to reflect changes in medical care.
~~17.~~ "Medicare claim" means a claim for Medicare covered services for an eligible person or member with Medicare coverage.
~~18.~~ "New hospital" means any hospital for which Medicare Cost Report data and claim and encounter data are not available for hospital rate development from any owner or operator of the hospital, during either the initial prospective rate year or rebasing.
~~19.~~ "NICU" means the neonatal intensive care unit of a hospital that has been classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.
~~20.~~ "Operating costs" means allowable accommodation and ancillary department hospital costs excluding capital and medical education costs.
~~21.~~ "Outlier" means a hospital claim or encounter in which the AHCCCS inpatient hospital days of care have operating costs per day that meet the criteria described in R9-22-712.
~~22.~~ "Outpatient hospital service" means a service provided in an outpatient hospital setting that does not result in an admission.
~~23.~~ "Ownership change" means a change in a hospital's owner, lessor, or operator as defined in 42 CFR 489.18(A).
~~24.~~ "Peer group" means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services.
"PPC" means prior period coverage, the period of time during which a member is eligible for AHCCCS covered services. The time-framerame is the 1st day of the month of application or the 1st eligible month whichever is later to the day a member is enrolled with the contractor. The contractor receives notification from the Administration of the member's enrollment.
~~25.~~ "Prospective rates" means inpatient or outpatient hospital rates defined in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, non-categorical discounts, and 1st-and 3rd-party payments regardless of billed charges or individual hospital costs.
~~26.~~ "Prospective rate year" means the period from October 1 of each year to September 30 of the following year, except for the initial prospective rate year, which is between March 1, 1993, and September 30, 1994.
~~27.~~ "Rebasing" means the process by which new Medicare Cost Report data, AHCCCS claim, and encounter data are collected and analyzed to reset periodically the inpatient hospital tiered per diem rates or the outpatient hospital cost-to-charge ratios.

~~28.~~ "Reinsurance" means a risk-sharing program provided by the Administration to contractors for the reimbursement of certain contract service costs incurred by a member or eligible person beyond a certain monetary threshold.
~~29.~~ "SDAD" means same day admit and discharge, which is a hospital stay with the admit and discharge occurring on the same calendar day.
~~30.~~ "Tier" means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure or revenue codes, peer group, or NICU classification level, or any combination of these items.
~~31.~~ "Tiered per diem" means a payment structure in which payment is made on a per-day basis depending upon the tier into which an AHCCCS inpatient hospital day of care is assigned.
~~32.~~ "Total inpatient hospital days" means the total number of days, including all hospital subprovider and nursery days, from the Medicare Cost Report for all payors. Observation days and swing bed days are not included.

ARTICLE 4. ~~CONTRACTS, ADMINISTRATION, AND STANDARDS~~ REPEALED

R9-22-401. ~~General~~ Repealed

~~**A.** A contract to provide services under AHCCCS shall be established between the Administration and a qualified provider of health care in conformance with the requirements in this Article. A contract and a subcontract entered into according to this Article is a public record and shall be on file with the Administration as specified in selected provisions of 42 and 45 CFR, as of October 1, 1995. These citations are incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~
~~**B.** A contractor shall not knowingly have a director, an officer, a partner, or a person with ownership of more than 5% of a contractor's equity who has been debarred or suspended by any federal agency specified in 42 U.S.C. 1396u-2, as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~
~~**C.** The Administration shall certify a contractor as a risk-bearing entity as specified in A.R.S. § 36-2903, as specified in RFP and contract, and as specified in 42 U.S.C. 1396b(m), as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~

R9-22-402. ~~Contracts~~ Repealed

~~**A.** Each contract between the Administration and a contractor shall be in writing and contain at least the following information:~~
~~1. The method and amount of compensation or other consideration to be received by the contractor.~~
~~2. The name and address of the contractor.~~
~~3. The population to be covered by the contract.~~
~~4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid.~~
~~5. The term of the contract, including the beginning and ending dates, as well as methods of extension, renegotiation, and termination.~~
~~6. A provision that the Director or the Secretary of the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness, or timeliness of services performed under the contract.~~
~~7. A description of patient, medical, and cost recordkeeping systems and a provision that the Director or the Secretary of the U.S. Department of Health and Human Services may audit and inspect any of the contractor's records that pertain to services performed and determinations of amounts payable under the contract. These records shall be maintained by the contractor for 5 years from the date of final payment or, for records relating to costs and expenses to which the Administration has taken exception, 5 years after the date of final disposition or resolution of the exception.~~
~~8. A provision to retain a specified percentage of periodic payments to the contractor, provide a reserve fund, or use another means to adjust the payments made to the contractor, based on utilization efficiency, including incentives for maintaining quality care and minimizing unnecessary inpatient services. This provision applies only to capped fee-for-service and AHCCCS-assembled network contractors and providers participating in a risk retention fund under R9-22-714.~~
~~9. A provision that the contractor maintain all forms, records, and statistical information required by the Director for purposes of audit and program management. This material, including files, correspondence, and related information pertaining to services rendered or claims for payments is subject to inspection and copying by the Administration and the U.S. Department of Health and Human Services during normal business hours at the place of business of the person or organization maintaining the materials.~~
~~10. A provision that the contractor safeguard information.~~
~~11. Any activities to be performed by the contractor affecting categorically eligible members that are related to 3rd-party liability requirements prescribed in 42 CFR 433, Subpart D, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~

12. ~~Functions that may be subcontracted, including a provision that any subcontract meets the requirements of 42 CFR 434.6(b), as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~
13. ~~A provision that the contractor arrange for the collection of any required co-payment.~~
14. ~~A provision that the contractor will not bill or attempt to collect from a member for any covered service except as may be authorized by statute or these rules.~~
15. ~~A provision that the contract will not be assigned or transferred without the prior written approval of the Director.~~
16. ~~Procedures for enrollment or re-enrollment of the covered population.~~
17. ~~Procedures and criteria for terminating the contract.~~
18. ~~A provision that any cost-sharing requirements imposed for services furnished to members comply with 42 CFR 447.50 through 447.58, as of October 1, 1995, which are incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~
19. ~~A provision that specifies the actuarial basis for computation of capitation fees.~~
20. ~~Procedures for terminating enrollment and choice of health professional.~~
21. ~~A provision that a contractor provide an internal grievance procedure that:~~
    a. ~~Is approved in writing by the Administration;~~
    b. ~~Provides prompt resolution; andEnsures the participation of persons with authority to provide prompt resolution.~~
22. ~~A provision that the contractor maintain an internal quality management system consistent with A.R.S. § 36-2903 and R9-22-522.~~
23. ~~A provision that the contractor submit marketing plans, procedures, and materials to the Administration for approval under R9-22-505 before implementation.~~
24. ~~A statement that all representations made by a contractor or authorized representative are truthful and complete to the best of their knowledge.~~
25. ~~A provision that the contractor is responsible for all tax obligations, Worker's Compensation insurance, and all other applicable insurance coverage, for itself and its employees, and that the Administration has no responsibility or liability for any of the taxes or insurance coverage.~~
26. ~~A provision that the contractor agrees to comply with all applicable statutes and rules.~~
27. ~~A provision that the contractor agrees to comply with the requirements regarding laboratory tests as specified in A.R.S. § 36-2903.~~

B. ~~Each contract shall include all provisions necessary to ensure compliance with the applicable requirements of 42 CFR 434, Subpart C, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~

R9-22-403. ~~Subcontracts~~ Repealed

A. ~~Approval. Any subcontract entered into by a contractor to provide covered services to AHCCCS members or any amendment to a subcontract shall be subject to review and approval by the Director. No subcontract alters the legal responsibility of a contractor to the Administration to ensure that all activities under the contract are carried out.~~

B. ~~Subcontracts. Each subcontract shall be in writing and include:~~
1. ~~That the subcontract is to be governed by, and construed in accordance with all laws, rules, and contractual obligations of the contractor.~~
2. ~~Provision to notify the Administration in the event the subcontract is amended or terminated.~~
3. ~~Provision that assignment or delegation of the subcontract is voidable unless prior written approval is obtained from the Administration.~~
4. ~~Provision to hold harmless the state, the Director, the Administration, and members in the event the contractor cannot or will not pay for covered services performed by the subcontractor.~~
5. ~~Provision that the subcontract and subcontract amendments are subject to review and approval by the Director as set forth in these rules and that a subcontract or subcontract amendment may be terminated, rescinded, or cancelled by the Director for a violation of these rules.~~
6. ~~Provision to hold harmless and indemnify the state, the Director, the Administration, and members against claim, liabilities, judgments, costs and expenses with respect to third parties, which may accrue against the state, the Director, the Administration, or members, through the negligence of the subcontractor.~~
7. ~~Provision that members are not to be held liable for payment to providers in the event of contractor's bankruptcy, in compliance with 42 CFR 434, Subpart C, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~
8. ~~The requirements contained in R9-22-402(A)(1) through (A)(7), (A)(9), (A)(10), (A)(14), (A)(15), (A)(17), and (A)(24) through (A)(26) but substituting the term "subcontractor" wherever the term "contractor" is used.~~

~~C.~~ ~~Waiver. A contractor may submit a written request to the Administration requesting a waiver of the requirement that the contractor subcontract with a hospital in the contractor's service area. The request shall set forth the reasons a waiver is believed to be necessary and shall state all efforts the contractor has made to secure a subcontract. For good cause shown, the Administration may waive the hospital subcontract requirement. The Administration shall consider the following criteria in deciding whether to waive the hospital subcontract requirement:~~

1. ~~The number of hospitals in the service area.~~
2. ~~The extent to which the contractor's primary care physicians have staff privileges at noncontracting hospitals in the service area.~~
3. ~~The size and population of, and the demographic distribution within, the service area.~~
4. ~~Patterns of medical practice and care within the service area.~~
5. ~~Whether the contractor has diligently attempted to negotiate a hospital subcontract in the service area.~~
6. ~~Whether the contractor has any subcontracts in adjoining service areas with hospitals that are reasonably accessible to the contractor's members in the service area.~~
7. ~~Whether the contractor's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.~~

R9-22-404. ~~Contract Amendments; Mergers; Reorganizations~~ Repealed

~~Any merger, reorganization, or change in ownership of a contractor shall require that the contractor submit the contract between the Administration and the contractor for amendment and prior approval by the Director. Additionally, any merger, reorganization, or change in ownership of a subcontractor that is related to or affiliated with the contractor shall constitute a contract amendment which requires the prior approval of the Director. To be effective, contract amendments shall be in writing and executed by the Director.~~

R9-22-405. ~~Suspension, Denial, Modification, or Termination of Contract~~ Repealed

~~A.~~ ~~General. The Director may suspend, deny, refuse or fail to renew, or terminate a contract or subcontract for good cause which may include the following reasons:~~

1. ~~Submitting any misleading, false, or fraudulent information with a claim for payment.~~
2. ~~Submitting false information for the purpose of obtaining greater compensation than that to which the contractor is legally entitled.~~
3. ~~Submitting an inaccurate or incomplete representation in the bidding process.~~
4. ~~Failing to disclose or make available to the Administration, or its authorized representatives, records of services provided to eligible persons or members and records of payment made for the services.~~
5. ~~Submitting false information for the purpose of obtaining authorization to provide services requiring authorization.~~
6. ~~Over-providing services or delivering unnecessary services by inducing or otherwise causing an eligible person or member to receive services or items not required by the person or member or by directly furnishing the services or items.~~
7. ~~Providing any services in violation of or not authorized by or otherwise precluded by licensure, certification, or other law.~~
8. ~~Breaching the terms or conditions of a contract.~~
9. ~~Having a member of the board, administrator, manager, or participating physician of a contractor convicted of a felony.~~
10. ~~Giving or accepting a rebate, kickback, or fee or portion of a fee, or charging for referral of an eligible person or member.~~
11. ~~Violating any provision of A.R.S. Title 36, Chapter 29, Title XIX of the Social Security Act, as amended, or any state or federal rule promulgated under those statutes.~~
12. ~~Demonstrating an inability to perform obligations under a contractor agreement by prior conduct.~~
13. ~~Being determined to have substantially breached a previous or existing contract agreement with another state agency.~~
14. ~~Being previously found ineligible to participate in federal or state assembled medical programs by the Administration or any other state or federal governmental agency.~~
15. ~~Failing to reimburse a subcontracting or noncontracting provider utilized by referral for the provision of medically necessary health care services to the contractor's members within 60 days of receipt of a valid claim unless a different period is specified by contract, or failing to ensure that future claims will be paid.~~
16. ~~Failing to reimburse a noncontracting provider or nonprovider for the provision of emergency medical services provided to the contractor's members within 60 days of receipt of a valid claim, or failing to ensure that future claims will be timely paid.~~
17. ~~Failing to provide and maintain quality health care service to eligible persons and members, as determined by standards established by state and federal statute or regulations.~~
18. ~~Being determined to be endangering or to have endangered either, by omission of commission, the health, safety, or well-being of an eligible person or member.~~

19. Becoming insolvent, or filing proceedings in bankruptcy or reorganization under the United States Code, or assigning rights or obligations under the contract without the prior written consent of the Administration.
20. Failing or refusing to comply with the reporting or disclosure requirement of 42 CFR 455, Subpart B, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
21. Being determined to have committed fraud or abuse in accordance with 42 CFR 455, Subpart A, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
22. Being convicted of a criminal offense related to involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act of any person who has an ownership or control interest in the contractor or subcontractor, or is an agent or managing employee of the contractor or subcontractor.
23. Failing to conform to and abide by the applicable laws or rules of Arizona, the United States federal government and the Administration.

B. Modification and termination of the contract without cause. The contract may be modified or terminated at any time by mutual consent of the Administration and contractor. Additionally, the Administration may terminate or suspend the contract in whole or in part without cause effective 30 days after mailing written notice of termination or suspension by certified mail, return receipt requested, to the contractor.

C. Notification. The Director shall provide the contractor written notice of intent to suspend, deny, fail to renew, or terminate a contract or related subcontract. The notice shall be provided to affected principals, enrolled members and other interested parties, and shall include the effective date of, and reason for, the action.

D. Records. All medical, financial, and other records shall be retained by a terminated contractor in accordance with federal and state laws and rules. Medical records or copies of medical records may be required to be submitted to the Director, or designee, within 10 working days of the effective date of contract termination.

R9-22-406. ~~Contract Compliance Sanction Alternative~~ Repealed

A. Instead of using the sanctioning authority prescribed in R9-22-405, the Director may impose 1 or more of the following sanctions upon a contractor that violates any provision of these rules or of an AHCCCS contract:
1. Suspend any or all further member enrollment, by choice or assignment, for a period of time commensurate with the nature, term, and severity of the violation.
2. Withhold a percentage of the contractor's capitation prepayment, commensurate with the nature, term, and severity of the violation.

B. The Director shall provide a contractor with written notice specifying the sanction alternative, grounds for the sanction, and either the length of suspension or the amount of prepayment to be withheld.

C. Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions provided for by contract.

ARTICLE 6. ~~REQUEST FOR PROPOSALS (RFP)~~ RFP AND CONTRACT PROCESS

R9-22-601. General Provisions

A. This Article applies to the expenditure of all public monies by the Administration for covered services under Articles 2 and 12 except as otherwise provided by law. The Administration shall ensure that it has conflict-of-interest safeguards for officers and employees of the state with responsibilities relating to contracts specified in 42 U.S.C. 1396u-2(d)(3), August 5, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. If it is deemed by the Administration to be in the best interest of the state, the Administration may cancel an RFP or reject any and all proposals, in whole or in part, as specified in the RFP. The reasons for cancellation or rejection shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if an RFP is cancelled or if a proposal is rejected in whole or in part.

C. The Administration may conduct an investigation of a person or organization who has ownership or management interests defined within 42 CFR 455.101, in corporate offerors and affiliated corporate organizations of an offeror. 42 CFR 455.101, September 30, 1986, is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

D. A proposal may be opened publicly and the name of the offeror announced and recorded. All other information contained in a proposal shall be confidential. A proposal shall be open for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state.

E. Failure by an offeror to supply information requested by the Administration is sufficient basis for rejection of the offeror's proposal by the Administration.

F. Disclosure of information pertaining to an offeror's proposal by the offeror to any other offeror or person prior to contract award is prohibited and may be grounds for rejecting a proposal.

A. The Director has full operational authority to adopt rules for the RFP process and the award of contracts under A.R.S. § 36-2906.

B. This Article applies to the expenditure of all public monies by the Administration for covered services under Articles 2 and 12 of this Chapter except as otherwise provided by law. The Administration shall ensure that it has conflict-of-interest safeguards for officers and employees of the state with responsibilities relating to contracts under 42 U.S.C. 1396u-2(d)(3), August 5, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

C. The Administration shall award contracts under A.R.S. §§ 36-2904 and 36-2906 to provide services under A.R.S. § 36-2907.

D. The Administration is exempt from the procurement code under A.R.S. § 41-2501.

E. The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2903 and dispose of the records under A.R.S. § 41-2550.

R9-22-602. ~~Request for Proposals (RFP); Contract Award~~ RFP

~~**A.** RFP content. The following items shall be included in an RFP:~~

~~1. The instructions and information to an offeror concerning the proposal submission requirements, including:~~
~~a. The deadline for submitting a proposal,~~
~~b. The address of the office at which a proposal is to be received,~~
~~c. The period during which the RFP shall remain open, and~~
~~d. Any special instructions and information;~~
~~2. The service description, covered populations, geographic coverage, and a delivery or performance schedule;~~
~~3. The contract terms and conditions, including bonding or other security requirements, if applicable;~~
~~4. The factors used to evaluate a proposal;~~
~~5. The location of and method of obtaining documents that are incorporated by reference;~~
~~6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;~~
~~7. The type of contract to be used and a copy of a proposed contract form or provisions;~~
~~8. The length of the contract service;~~
~~9. A requirement for cost or pricing data;~~
~~10. The minimum RFP requirements; and~~
~~11. A provision requiring an offeror to certify that the submission of a proposal does not involve collusion or other anti-competitive practices.~~

~~**B.** Evaluation of a proposal.~~

~~1. The Administration shall evaluate a proposal based on the evaluation factors listed in the RFP.~~
~~2. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Administration shall provide an offeror fair treatment with respect to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.~~
~~3. The Administration may issue a written request for best and final offers. The request shall state the date, time, and place for the submission of best and final offers.~~
~~4. Best and final offers may be requested only once unless the Administration determines that it is advantageous to the state to request additional best and final offers. The written request for best and final offers shall inform the offeror that if the offeror does not submit a notice of withdrawal or a best and final offer, the immediate previous offer shall be construed as the offeror's best and final offer.~~
~~5. The Administration shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be part of the contract file and public record.~~

~~**C.** Contract award. The Administration shall award the contract to the responsible and responsive offeror whose proposal is deemed most advantageous to the state. If the Administration determines that multiple contracts are in the best interest of the state, the Administration may award multiple contracts. The contract file shall contain the basis on which the award is made.~~

A. RFP content. The Administration shall include the following items in any RFP under this Article:

1. The instructions and information to an offeror concerning the proposal submission requirements, including:
   a. The deadline for submitting a proposal,
   b. The address of the office at which a proposal is to be received,
   c The period during which the RFP shall remain open, and
   d. Any special instructions and information;
2. The scope of covered services under Article 2 of this Chapter, A.R.S. §§ 36-2906 and 36-2907, covered populations, geographic coverage, service and performance requirements, and a delivery or performance schedule;
3. The contract terms and conditions, including bonding or other security requirements, if applicable;
4. The factors used to evaluate a proposal;

5. The location and method of obtaining documents that are incorporated by reference;
6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;
7. The type of contract to be used and a copy of a proposed contract form or provisions;
8. The length of the contract service;
9. A requirement for cost or pricing data;
10. The minimum RFP requirements; and
11. A provision requiring an offeror to certify that the submission of a proposal does not involve collusion or other anti-competitive practices.

B. Proposal process.

1. After the deadline for submitting proposals, the Administration may open a proposal publicly and announce and record the name of the offeror. The Administration shall keep all other information contained in a proposal confidential. The Administration shall open a proposal for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state under A.R.S. § 36-2906.
2. The Administration shall evaluate a proposal based on the GSA and the evaluation factors listed in the RFP.
3. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Administration shall provide an offeror fair treatment with respect to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.
4. The Administration shall allow for the adjustment of covered services by expansion, deletion, segregation, or combination in order to secure the most financially advantageous proposals for the state.
5. The Administration shall have the option to conduct an investigation of a person or organization who has ownership or management interests in corporate offerors and affiliated corporate organizations of an offeror. Ownership or management interests are defined within 42 CFR 455.101, September 30, 1986, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
6. The Administration may issue a written request for best and final offers. The Administration shall state in the request the date, time, and place for the submission of best and final offers.
7. The Administration may request best and final offers only once unless the Administration determines that it is advantageous to the state to request additional best and final offers. The Administration shall state in the written request for best and final offers that if the offeror does not submit a notice of withdrawal or a best and final offer, the Administration shall take the immediate previous offer as the offeror's best and final offer.

C. Proposal rejection.

1. The Administration may reject an offeror's proposal if the offeror fails to supply the information requested by the Administration.
2. The offeror shall not disclose information pertaining to its proposal to any other offeror prior to contract award. The offeror may disclose proposal information to a person other than another offeror provided that the recipient agrees to keep the information confidential until contract award. Disclosure may be grounds for rejecting a proposal.
3. The Administration shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be part of the contract file and public record.

D. Proposal cancellation. If the Administration determines that it is in the best interest of the state, the Administration may cancel a RFP or reject any and all proposals, in whole or in part, under the RFP. The reasons for cancellation or rejection shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a RFP is cancelled or if a proposal is rejected in whole or in part.

R9-22-603. ~~Contract Records~~ Contract Award

~~All contract records shall be retained for a period of 5 years and disposed of under A.R.S. § 41-2550.~~

The Administration shall award a contract to the responsible and responsive offeror whose proposal is determined most advantageous to the state under A.R.S. § 36-2906. If the Administration determines that multiple contracts are in the best interest of the state, the Administration may award multiple contracts. The contract file shall contain the basis on which the award is made.

R9-22-604. Contract or Proposal Protests; Appeals

~~**A.** Grievances related to contract performance. This Section shall not apply to grievances related to contract performance. Any contract performance grievance shall be governed by R9-22-804.~~

~~**B.** Resolution of a proposal protest. The procurement officer issuing an RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.~~

~~**C.** Filing of a protest.~~

~~1. An interested party may file a protest with the procurement officer regarding:~~
~~a. An RFP issued by the Administration,~~

b. A proposed award, or
c. An award of a contract.

2. The protest shall be in writing and shall include the following information:
a. The name, address, and telephone number of the protester;
b. The signature of the protester or protester's representative;
c. Identification of an RFP or contract number;
d. A detailed statement of the legal and factual grounds of the protest including copies of any relevant documents; and
e. The relief requested.

D. Time for filing a protest.
1. A protest based on alleged improprieties in an RFP shall be filed before the due date for receipt of proposals.
2. A protest alleging improprieties that do not exist in the original RFP but are subsequently incorporated into the RFP before the due date for receipt of proposals shall be filed prior to the amended due date for receipt of proposals.
3. In cases other than those covered in subsections (D)(1) and (2), a protest shall be filed within 10 days after the protester knows or should have known the basis of the protest.

E. Stay of procurements during the protest. If a protest is filed before the contract award, the procurement officer may issue a written stay of the contract award if:
1. A reasonable probability exists that the protest will be sustained, and
2. The stay of the contract award is not contrary to the best interest of the state.

F. Decision by the procurement officer.
1. The procurement officer shall issue a written decision within 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
2. The procurement officer shall furnish a copy of the decision to the protester by:
a. Certified mail, return receipt requested; or
b. Any method that provides evidence of receipt.
3. The Administration may extend, for good cause, the time limit for decisions in subsection (F)(1) for a time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
4. If the procurement officer fails to issue a decision within the time-limits in subsection (F)(1) or (3) the protester may proceed as if the procurement officer issued an adverse decision.

G. Remedies.
1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
a. Seriousness of the procurement deficiency,
b. Degree of prejudice to other interested parties or to the integrity of the RFP process,
c. Good faith of the parties,
d. Extent of performance,
e. Costs to the state, and
f. Urgency of the procurement.
3. An appropriate remedy may include 1 or more of the following:
a. Terminate the contract;
b. Reissue the RFP;
c. Issue a new RFP;
d. Award a contract consistent with statutes, rules, and the terms of the RFP; or
e. Any relief determined necessary to ensure compliance with applicable statutes and regulations.

H. Appeals to the Director.
1. An interested party shall file an appeal from a decision by the procurement officer with both the Director and the procurement officer within 5 days from the date the decision is received. The date the decision is received shall be determined according to R9-22-604(F)(2).
2. The appeal shall contain:
a. The information required in subsection (C)(2),
b. A copy of the decision of the procurement officer,
c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
d. A request for hearing unless the interested party requests that the Director's decision be based solely upon the contract record.

~~**I.** Stay of contract award during an appeal to the Director. If an appeal is filed before a contract award and the contract award is stayed by the procurement officer under subsection (E), the filing of an appeal to the Director shall automatically continue the stay unless the Director issues a written determination that the contract award is necessary to protect the best interest of the state.~~

~~**J.** Dismissal. No appeal hearing shall be scheduled, and the Director shall dismiss an appeal with a written determination if:~~

~~1. The appeal does not state a basis for protest,~~

~~2. The appeal is untimely under subsection (H), or~~

~~3. The appeal is moot.~~

~~**K.** Hearing. Hearings requested under this rule shall be conducted under Article 8.~~

A. Disputes related to contract performance. This Section shall not apply to disputes related to contract performance. Any contract performance dispute shall be governed by Article 8 of this Chapter.

B. Resolution of a proposal protest. The procurement officer issuing a RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.

C. Filing of a protest.

1. A person may file a protest with the procurement officer regarding:
   a. A RFP issued by the Administration,
   b. A proposed award, or
   c. An award of a contract.
2. A protester shall submit a written protest and include the following information:
   a. The name, address, and telephone number of the protester;
   b. The signature of the protester or protester's representative;
   c. Identification of a RFP or contract number;
   d. A detailed statement of the legal and factual grounds of the protest including copies of any relevant documents; and
   e. The relief requested.

D. Time for filing a protest.

1. A protester filing a protest alleging improprieties in a RFP shall file the protest before the due date for receipt of proposals.
2. A protester filing a protest alleging improprieties that do not exist in the original RFP but are subsequently incorporated into the RFP before the due date for receipt of proposals shall file the protest prior to the amended due date for receipt of proposals.
3. In cases other than those covered in subsections (D)(1) and (2), a protester shall file a protest within 10 days after the protester knows or should have known the basis of the protest.

E. Stay of procurement during the protest. If a protester files a protest before the contract award, the procurement officer may issue a written stay of the contract award if:

1. A reasonable probability exists that the protest will be sustained, and
2. The stay of the contract award is in the best interest of the state.

F. Decision by the procurement officer.

1. The procurement officer shall issue a written decision within 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
2. The procurement officer shall furnish a copy of the decision to the protester by:
   a. Certified mail, return receipt requested; or
   b. Any method that provides evidence of receipt.
3. The Administration may extend, for good cause, the time-limit for decisions in subsection (F)(1) for a time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
4. If the procurement officer fails to issue a decision within the time-limits in subsection (F)(1) or (3), the protester shall have the option to proceed as if the procurement officer issued an adverse decision.

G. Remedies.

1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
   a. Seriousness of the procurement deficiency,
   b. Degree of prejudice to other interested parties or to the integrity of the RFP process,
   c. Good faith of the parties,
   d. Extent of performance,
   e. Costs to the state, and

f. Urgency of the procurement.

3. An appropriate remedy may include one or more of the following:
   a. Terminate the contract;
   b. Reissue the RFP;
   c. Issue a new RFP;
   d. Award a contract consistent with statutes, rules, and the terms of the RFP; or
   e. Any relief determined necessary to ensure compliance with applicable statutes and regulations.

H. Appeals to the Director.

1. A person shall file an appeal about a procurement officer's decision with both the Director and the procurement officer within five days from the date the decision is received. The date the decision is received shall be determined under subsection (F)(2).
2. The appeal shall contain:
   a. The information required in subsection (C)(2),
   b. A copy of the procurement officer's decision,
   c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
   d. A request for hearing unless the person requests that the Director's decision be based solely upon the contract record.

I. Stay of contract award during an appeal to the Director. The Director shall automatically continue the stay of a contract award if:

1. An appeal is filed before a contract award, and
2. The procurement officer issues a stay of the contract award under subsection (E), unless
3. The Director issues a written determination that the contract award is necessary to protect the best interest of the state.

J. Dismissal. The Director shall not schedule a hearing and shall dismiss an appeal with a written determination if:

1. The appeal does not state a basis for protest,
2. The appeal is untimely under subsection (H)(1), or
3. The appeal is moot.

K. Hearing. Hearings filed under this rule shall be conducted under Article 8 of this Chapter.

R9-22-605. ~~Repealed~~ Waiver of Contractor's Subcontract with Hospitals

If a contractor is unable to obtain a subcontract with a hospital, the contractor may request in writing a waiver from the Administration as allowed by A.R.S. § 36-2906. The contractor shall state in the request the reasons a waiver is believed to be necessary and all efforts the contractor has made to secure a subcontract. The Administration shall consider the following criteria in deciding whether to grant the waiver:

1. The number of hospitals in the service area.
2. The extent to which the contractor's physicians have staff privileges at noncontracting hospitals in the service area.
3. The size and population of, and the demographic distribution within, the service area.
4. Patterns of medical practice and care within the service area.
5. Whether the contractor has diligently attempted to negotiate a hospital subcontract with local hospitals capable of serving members in the service area.
6. Whether the contractor has any subcontracts in adjoining service areas with hospitals that are reasonably accessible to the contractor's members in the service area.
7. Whether the contractor's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.

R9-22-606. Contract Compliance Sanction

A. The Director may impose one or more of the following sanctions upon a contractor that violates any provision of these rules or of an AHCCCS contract:

1. Suspend any or all further member enrollment, by choice or assignment, for a period of time commensurate with the nature, term, and severity of the violation.
2. Withhold a percentage of the contractor's capitation prepayment, commensurate with the nature, term, and severity of the violation.

B. The Director shall provide a contractor with written notice specifying grounds for the sanction and either the length of suspension or the amount to be forfeited or the prepayment to be withheld under A.R.S. § 36-2903.

C. Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions as provided in contract under A.R.S. § 36-2903.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. Scope of the Administration's Liability; ~~Payments to Contractors~~

~~**A.**~~ The Administration shall bear no liability for providing covered services to or completing a plan of treatment for any member ~~or eligible person~~ beyond the date of eligibility termination. ~~of the individual's eligibility or enrollment.~~

~~**B.** The Administration shall make all payments to a contractor in accordance with the terms and conditions of the contract executed between the contractor and the Administration and in accordance with these rules.~~

~~**C.** The Administration shall bear no liability for subcontracts that a contractor executes with other parties for the provision of administrative or management services, medical services, or covered health care services, or for any other purpose. A contractor shall indemnify and hold the Administration harmless from any and all liability arising from the contractor's subcontracts, shall bear all costs of defense of any litigation over the liability, and shall satisfy in full any judgment entered against the Administration in litigation involving the contractor's subcontracts.~~

~~**D.** The Administration shall make capitation payments monthly to a contractor who meets the requirements in A.R.S. § 36-2903(N).~~

R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care

A. For purposes of ~~program and~~ contractor liability, an emergency medical or acute mental health condition of a member shall be subject to reimbursement only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of A.R.S. § ~~36-2909(E)~~ 36-2909 and Article 2 of ~~these rules~~ this Chapter.

B. Subject to subsection (A), if a member cannot be transferred following stabilization to a facility that has a subcontract with the contractor of record, the contractor of record shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided to the member before the ~~date of discharge~~ discharge date or transfer ~~in accordance with payment standards in~~ under R9-22-705.

C. If a member refuses transfer from a ~~nonprovider~~ noncontracting provider or noncontracting hospital to a hospital affiliated with the member's contractor of record, neither the Administration nor the contractor shall be liable for any costs incurred after the date of refusal if:

1. After consultation with the member's contractor of record, the member continues to refuse the transfer; and
2. The member has been provided and signs a written statement, before the date of transfer of liability, informing the member of the medical and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by ~~2~~ two witnesses indicating that the member was informed may be substituted.

R9-22-714. ~~Contractor risk retention fund (AHCCCS-assembled networks)~~ Payments to Providers

~~Contractor risk pools may be established by the Administration for AHCCCS-assembled networks as follows:~~

~~1. Fifteen percent of the total capitation to be paid to primary care contractors may be retained by the Administration. If the Administration determines to do so, to prevent over utilization or other misuse of the system, 10% shall be deposited into an inpatient risk pool fund and 5% shall be deposited into a specialty care risk pool fund. Hospital utilization and the frequency of referrals shall be monitored on a monthly basis to compare actual utilization experience with targeted utilization. Utilization targets shall be identified in each network. If actual utilization is below such utilization targets, the entire amount within risk pools shall be returned to the primary care contractors on a quarterly basis. If actual utilization exceeds targets, the costs associated with such excess utilization shall be deducted by the Administration from the risk pools on a dollar-for-dollar basis. Any residual funds remaining in a risk pool shall be distributed to the primary care contractor on a quarterly basis.~~

~~2. Ten percent of the capitation paid to specialty care providers may be withheld by the Administration and deposited into an inpatient risk pool fund. If the Administration determines to do so to prevent over utilization or other misuse of the system, hospital utilization shall be monitored on a monthly basis to compare actual utilization experience with targeted utilization. Hospital utilization targets shall be identified in each network. If actual utilization is below utilization targets, the entire amount in the inpatient risk pool shall be returned to the specialty care contractor following the close of the contract year. If actual utilization exceeds targets, costs associated with excess utilization shall be deducted by the Administration from the risk pool on a dollar-for-dollar basis. Any residual funds remaining in the risk pool shall be distributed to the specialty care contractor, on a quarterly basis.~~

A. As a prerequisite for receiving reimbursement for covered services provided to a member, a provider shall sign a provider agreement with the Administration which establishes the terms and conditions of participation and payment under A.R.S. § 36-2904.

B This subsection does not apply to reimbursement of emergency services and services provided during PPC under Article 2 of this Chapter.

R9-22-716. Specialty Contracts

~~The Director may at any time negotiate or contract on behalf of providers, noncontracting providers, and the Administration for specialized hospital and medical services including, but not limited to, neonatology, neurology, cardiology, and burn care.~~

~~If the Director contracts for specialized services, contractors of record may be required to include the services within their delivery networks and make contractual modifications necessary to carry out this Section. Specialty contractors shall take precedence over all other contractual arrangements between contractors of record and their subcontractors. Specialty contractors may require interim payments to specialty contractors on behalf of contractors of record for contract services received by members. Interim payments to specialty contractors may be deducted from capitation payments, performance bonds, or other monies for payment on behalf of contractors of record. If the Administration and a hospital that performed a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.~~

The Director may contract with entities for specialized hospital and medical services including, but not limited to:

1. Neonatology,
2. Neurology,
3. Cardiology,
4. Burn care under A.R.S. § 36-2903.01, and
5. Transplant services.

R9-22-719. Contractor Performance Measure Outcomes

The Administration may retain a specified percentage of capitation reimbursement in order to distribute to contractors based on their performance measure outcomes under A.R.S. § 36-2904. The Administration shall notify contractors 60 days prior to a new contract year if this methodology is implemented. The Administration shall specify the details of the reimbursement methodology in contract.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

1. Sections Affected	**Rulemaking Action**
R9-28-101	Amend
Article 6	Amend
R9-28-601	Amend
R9-28-602	Amend
R9-28-603	Repeal
R9-28-603	New Section
R9-28-604	Repeal
R9-28-604	New Section
R9-28-605	Repeal
R9-28-605	New Section
R9-28-606	Repeal
R9-28-606	New Section
R9-28-607	Repeal
R9-28-608	Repeal
R9-28-701	Amend
R9-28-707	Amend
R9-28-710	Repeal
R9-28-714	New Section
R9-28-715	New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. §§ 36-2932 and 36-2944

Implementing statute: A.R.S. §§ 36-2932 and 36-2944

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 3051, July 13, 2001

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS, Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

5. An explanation of the rule, including the agency's reasons for initiating the rule:

These rules define the contracts/RFP process for AHCCCS' long-term care program. The Administration is amending these rules to make the rules more clear, concise, and understandable and comply with the January 2002 G.R.R.C. deadline for the five-year review.

6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

7. showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

The contractors, members, and the Arizona Health Care Cost Containment System Administration (AHCCCSA) will be nominally impacted by the changes to the rule language. The Administration is amending these rules to:

Increase clarity and conciseness and

Remove language that is more appropriate in contract.

There will be no fiscal impact on businesses or political subdivisions since the proposed rule language changes are nonsubstantive and are intended to streamline and clarify the existing rules. Language that does not clearly present policies or procedures is clarified. Citations to documents incorporated in the rule are updated, as needed. Duplicative language that appropriately exists in contract is deleted. There will be a minor impact for the cost of printing the copies for the rule, once adopted and approved.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS, Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: October 2, 2001

Time: 9:00 a.m.

Location: AHCCCS
701 E. Jefferson, Gold Room
Phoenix, AZ 85034

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location:	Yuma City Hall, City Council Chambers 180 W. 1st. St. Yuma, AZ 85364
Parking:	Parking is next door at the Armory.
Nature:	Public Hearing

Date:	October 2, 2001
Time:	9:00 a.m.
Location:	ALTCS: Arizona Long Term Care System 484 E. Wilcox Drive Sierra Vista, AZ 85635
Nature:	Public Hearing

Date:	October 2, 2001
Time:	9:00 a.m.
Location:	ALTCS: Arizona Long Term Care System 110 So. Church, Suite 3250 Tucson, AZ 85701
Nature:	Video Conference Oral Proceeding

Date:	October 2, 2001
Time:	9:00 a.m.
Location:	ALTCS: Arizona Long Term Care System 3480 E. Route 66 Flagstaff, AZ 86004
Nature:	Video Conference Oral Proceeding

The Administration shall accept written comments until 5:00 p.m., Tuesday, October 2, 2001. Please submit comments at the public hearing listed above or to the following person:

Name:	Cheri Tomlinson, Federal and State Policy Administrator
Address:	AHCCCS, Office of Policy Analysis and Coordination 801 E. Jefferson, Mail Drop 4200 Phoenix, AZ 85034
Telephone	(602) 417-4534
Fax:	(602) 256-6756

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

Description	Date	Location
42 CFR 488, Subpart F	May 17, 1999	R9-28-606(B)
42 U.S.C. 1396r	August 5, 1997	R9-28-606(B)

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 1. DEFINITIONS

Section
R9-28-101. General Definitions

ARTICLE 6. ~~REQUEST FOR PROPOSALS~~ RFP AND CONTRACT PROCESS

Section
R9-28-601. General Provisions
R9-28-602. ~~Request for Proposals (RFP); Contract Award~~ RFP
R9-28-603. ~~Contract or Proposal Protests; Appeals~~ Contract Award
R9-28-604. ~~Contracts~~ Contract or Proposal Protests; Appeals
R9-28-605. ~~Subcontracts~~ Waiver of Contractor's Subcontract with Hospitals
R9-28-606. ~~Specialty Contracts~~ Contract Compliance Sanction
R9-28-607. ~~Contract Amendments; Mergers; Reorganizations~~ Repealed
R9-28-608. ~~Contract Suspension, Denial, Modification, Termination, or Sanction~~ Repealed

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-28-701. Scope of the Administration's ~~liability~~ Liability
R9-28-707. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care
R9-28-710. ~~Capitation Payments to Program Contractors~~ Repealed
R9-28-714. Payments to Providers
R9-28-715. Specialty Contracts

ARTICLE 1. DEFINITIONS

R9-28-101. General Definitions

A. Location of definitions. Definitions applicable to Chapter 28 are found in the following:

Definition	Section or Citation
"211"	42 CFR 435.211
"217"	42 CFR 435.217
"236"	42 CFR 435.236
"Administration"	A.R.S. § 36-2931
"ADHS"	R9-28-111
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
"Algorithm"	R9-28-104
"ALTCS"	A.R.S. § 36-2932
"ALTCS acute care services"	R9-28-104
"Alternative HCBS setting"	R9-28-101
"Ambulance"	R9-22-102
"Bed hold"	R9-28-102
"Behavior intervention"	R9-28-102
"Behavior management services"	R9-28-111
"Behavioral health paraprofessional"	R9-28-111
"Behavioral health professional"	R9-28-111
"Behavioral health service"	R9-28-111
"Behavioral health technician"	R9-28-111
"Billed charges"	R9-22-107
"Board-eligible for psychiatry"	R9-28-111
"Capped fee-for-service"	R9-22-101
"Case management plan"	R9-28-101

"Case management services"	R9-28-111
"Case manager"	R9-28-101
"Case record"	R9-22-101
"Categorically-eligible"	A.R.S. § 36-2934
"Certification"	R9-28-105
"Certified psychiatric nurse practitioner"	R9-28-111
"CFR"	R9-28-101
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-28-111
"Community Spouse"	R9-28-104
"Contract"	R9-22-101
"Contractor"	R9-22-101
"County of fiscal responsibility"	R9-28-107
"Covered services"	R9-22-102
"CPT"	R9-22-107
"CSRD"	R9-28-104
"Day"	R9-22-101
"DES Division of Developmental Disabilities"	A.R.S. § ~~36-1~~ 36-551
"De novo hearing"	R9-28-111
"Developmental disability"	A.R.S. § 36-551
"Diagnostic services"	R9-22-102
"Director"	R9-22-101
"Disenrollment"	R9-22-117
"DME"	R9-22-102
"Eligible person"	A.R.S. § 36-2931
"Emergency medical services"	R9-22-102
"Encounter"	R9-22-107
"Enrollment"	R9-22-117
"Estate"	A.R.S. § 14-1201
"Evaluation"	R9-28-111
"Facility"	R9-22-101
"Factor"	R9-22-101
"Fair consideration"	R9-28-104
"FBR"	R9-22-101
"Grievance"	R9-22-108
"GSA"	R9-22-101
"Guardian"	R9-22-116
"HCBS"	A.R.S. §§ 36-2931 and 36-2939
"Hearing"	R9-22-108
"Home"	R9-28-101
"Home health services"	R9-22-102
"Hospital"	R9-22-101
"ICF-MR"	42 CFR 435.1009 and 440.150
"IHS"	R9-28-101
"IMD"	42 CFR 435.1009
"Indian"	P.L. 94-437
"Inpatient psychiatric facilities for individuals under age 21"	R9-28-111
"Institutionalized"	R9-28-104
"Interested Party"	R9-28-106
"JCAHO"	R9-28-101
"License" or "licensure"	R9-22-101
"Medical record"	R9-22-101
"Medical services"	R9-22-101
"Medical supplies"	R9-22-102
"Medically eligible"	R9-28-104
"Medically necessary"	R9-22-101
"Member"	A.R.S. § 36-2931
"Mental disorder"	R9-28-111

"MMMNA"	R9-28-104
"NF"	42 U.S.C. 1396r(a)
"Noncontracting provider"	A.R.S. § 36-2931
"Occupational therapy"	R9-22-102
"Partial care"	R9-28-111
"PAS"	R9-28-103
"PASARR"	R9-28-103
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	R9-22-102
"Post-stabilization services"	42 CFR 438.114
"Practitioner"	R9-22-102
"Primary care provider"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Prior period coverage"	R9-28-101
"~~Prior quarter period~~"	R9-28-101
"Private duty nursing services"	R9-22-102
"Program contractor"	A.R.S. § 36-2931
"Provider"	A.R.S. § 36-2931
"Prudent layperson standard"	42 U.S.C. 1396u-2
"Psychiatrist"	R9-28-111
"Psychologist"	R9-28-111
"Psychosocial rehabilitation"	R9-28-111
"Quality management"	R9-22-105
"RBHA"	R9-28-111
"Radiology"	R9-22-102
"Reassessment"	R9-28-103
"Redetermination"	R9-28-104
"Referral"	R9-22-101
"Reinsurance"	R9-22-101
"Representative"	R9-28-104
"Respiratory therapy"	R9-22-102
"Respite care"	R9-28-102
"RFP"	R9-22-106
"Room and board"	R9-28-102
"Scope of services"	R9-22-102
"Screening"	R9-28-111
"Speech therapy"	R9-22-102
"Spouse"	R9-28-104
"SSA"	P.L. 103-296, Title I
"SSI"	R9-22-101
"Subcontract"	R9-22-101
"Substance abuse"	R9-28-111
"Treatment"	R9-28-111
"Utilization management"	R9-22-105
"Ventilator dependent"	R9-28-102

B. General definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

"AHCCCS" is defined in 9 A.A.C. 22, Article 1.

"ALTCS" means the Arizona Long-term Care System as authorized by A.R.S. § 36-2932.

"Alternative HCBS setting" means a living arrangement approved by the Director and licensed or certified by a regulatory agency of the state, where a member may reside and receive HCBS including:

For a person with a developmental disability (DD) specified in A.R.S. § 36-551:

Community residential setting defined in A.R.S. § 36-551;

Group home defined in A.R.S. § 36-551;

State-operated group home defined in A.R.S. § 36-591;

Family foster home defined in 6 A.A.C. 5, Article 58;

Group foster home defined in 6 A.A.C. 5, Article 59;

Licensed residential facility for a person with traumatic brain injury specified in A.R.S. § 36-2939; and

Behavioral health service agency specified in A.R.S. § 36-2939(B)(2) and 9 A.A.C. 20, Articles 6, 7, and 8 for Levels I, II, or III;

For a person who is elderly or physically disabled (EPD), and the facility, setting, or institution is registered with AHCCCS:

Adult foster care homes defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939; an assisted living home or residential unit, as defined in A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939.

Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939; and

Behavioral health service agency specified in A.R.S. § 36-2939(C) and 9 A.A.C. 20, Articles 6, 7, and 8 for Levels I and II.

Alzheimer's treatment assistive living facility demonstration pilot project as specified in Laws 1999, Ch. 313, § 35.

"Capped fee-for-service" is defined in 9 A.A.C. 22, Article 1.

"Case management plan" means a service plan developed by a case manager that involves the overall management of a member's care, and the continued monitoring and reassessment of the member's need for services.

"Case manager" means a person who is either a degreed social worker, a licensed registered nurse, or a person with a minimum of 2 years of experience in providing case management services to a person who is elderly and physically disabled or has developmental disabilities.

"Case record" is defined in 9 A.A.C. 22, Article 1.

"CFR" means Code of Federal Regulations, unless otherwise specified in this Chapter.

"Contract" is defined in 9 A.A.C. 22, Article 1.

"Day" is defined in 9 A.A.C. 22, Article 1.

"DES Division of Developmental Disabilities" is defined in A.R.S. § 36-551.

"Disenrollment" is defined in 9 A.A.C. 22, Article 1.

"Eligible person" is defined in A.R.S. § 36-2931.

"Enrollment" is defined in 9 A.A.C. 22, Article 1.

"Facility" is defined in 9 A.A.C. 22, Article 1.

"Factor" is defined in 9 A.A.C. 22, Article 1.

"FBR" means Federal Benefit Rate and is defined in 9 A.A.C. 22, Article 1.

"HCBS" means home and community based services defined in A.R.S. §§ 36-2931 and 36-2939.

"Home" means a residential dwelling that is owned, rented, leased, or occupied at no cost to a member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as a:

Health care institution defined in A.R.S. § 36-401;

Residential care institution defined in A.R.S. § 36-401;

Community residential facility defined in A.R.S. § 36-551; or

Behavioral health service facility defined in 9 A.A.C. 20, Articles 6, 7, and 8.

"Hospital" is defined in 9 A.A.C. 22, Article 1.

"GSA" is defined in 9 A.A.C. 22, Article 1.

"ICF-MR" means an intermediate care facility for the mentally retarded and is defined in 42 CFR 435.1009 and 440.150.

"IHS" means the Indian Health Services.

"Indian" is defined in P.L. 94-437.

"JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.

"License" or "licensure" is defined in 9 A.A.C. 22, Article 1.

"Medical record" is defined in 9 A.A.C. 22, Article 1.

"Medical services" is defined in 9 A.A.C. 22, Article 1.

"Medically necessary" is defined in 9 A.A.C. 22, Article 1.

"Member" is defined in A.R.S. § 36-2931.

"NF" means nursing facility and is defined in 42 U.S.C. 1396r(a).

"Noncontracting provider" is defined in A.R.S. § 36-2931.

"Prior period coverage" means ~~the period of time from the 1st day of the month of application or the 1st eligible month whichever is later to the day a member is enrolled with the program contractor. The program contractor receives notification from the Administration of the member's enrollment~~ "PPC" as defined in 9 A.A.C. 22, Article 1.

~~"Prior quarter period" means the 3 calendar months immediately preceding the month of application during which a member may be eligible for services covered under this Chapter, retroactively under federal law and under A.R.S. § 36-2937.~~

"Program contractor" is defined in A.R.S. § 36-2931.

"Provider" is defined in A.R.S. § 36-2931.

"Referral" is defined in 9 A.A.C. 22, Article 1.

"Reinsurance" is defined in 9 A.A.C. 22, Article 1.

"SSA" means Social Security Administration defined in P.L. 103-296, Title I.

"SSI" is defined in 9 A.A.C. 22, Article 1.

"Subcontract" is defined in 9 A.A.C. 22, Article 1.

ARTICLE 6. ~~REQUEST FOR PROPOSALS~~ RFP AND CONTRACT PROCESS

R9-28-601. General Provisions

A. The Director has full operational authority to adopt rules for the RFP process and the award of contract under A.R.S. § 36-2944.

~~A.~~B. The Administration shall follow the provisions ~~specified in~~ under 9 A.A.C. 22, ~~Articles 4 and 6~~ Article 6 for ALTCS members, subject to limitations and exclusions ~~specified in~~ under that Article, unless otherwise specified in this Chapter. All references to the Administration also shall apply to ALTCS.

~~B.~~C. The Administration shall ~~establish~~ award contracts under A.R.S. § 36-2932 to provide services ~~as specified in~~ under A.R.S. § ~~36-2940~~ 36-2939.

D. The Administration is exempt from the procurement code under A.R.S. § 41-2501.

~~C.~~E. ~~All contract records shall follow the provisions of A.R.S. § 36-2932 and A.A.C. R9-22~~ The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2932 and dispose of the records under A.R.S. § 41-2550.

R9-28-602. ~~Request for Proposals (RFP); Contract Award~~ RFP

The ALTCS RFP for ~~an EPD~~ a program contractor serving members who are ~~elderly or physically disabled~~ EPD shall be ~~in accordance with~~ under A.R.S. §§ 36-2944 and 36-2939, A.A.C. R9-22-602, and ~~A.A.C. R9-22-604~~ Articles 2 and 11 of this Chapter.

R9-28-603. ~~Contract or Proposal Protests; Appeals~~ Contract Award

~~The ALTCS grievances related to contract performance shall be in accordance with A.A.C. R9-22-602, and all references in that rule shall apply to ALTCS.~~

The Administration shall award a contract under A.R.S. § 36-2944 and A.A.C. R9-22-603.

R9-28-604. ~~Contracts~~ Contract or Proposal Protests; Appeals

~~All ALTCS contracts shall meet the requirements in accordance with A.R.S. §§ 36-2932 and 36-2944 and A.A.C. R9-22-402. In addition, the Administration may extend existing contracts as specified in the contract.~~

Contract or proposal protests or appeals shall be under A.A.C. R9-22-604 and Article 8 of this Chapter.

R9-28-605. ~~Subcontracts~~ Waiver of Contractor's Subcontract with Hospitals

~~All ALTCS subcontracts shall be entered in accordance with A.R.S. § 36-2932 and A.A.C. R9-22-403, and all references in that rule shall apply to ALTCS.~~

A waiver of a contractor's subcontract with hospitals shall be under A.A.C. R9-22-605.

R9-28-606. ~~Specialty Contracts~~ Contract Compliance Sanction

~~The Director shall negotiate specialty contracts under A.A.C. R9-22-716.~~

A. The Administration shall follow sanction provisions under A.A.C. R9-22-606 and all references in that rule shall apply.

B. The Administration shall apply remedies found in 42 CFR 488, Subpart F, effective May 17, 1999, incorporated by reference and on file with the Administration and the Office of the Secretary of State, for a nursing facility that does not meet requirements of participation under 42 U.S.C. 1396r effective August 5, 1997, incorporated by reference and on file with the Administration and the Office of the Secretary of State. These incorporations by reference contain no future editions or amendments.

R9-28-607. ~~Contract Amendments; Mergers; Reorganizations~~ Repealed

~~**A.** Any amendments, mergers or reorganizations regarding ALTCS shall be in accordance with A.A.C. R9-22-404.~~

~~**B.** If a program contractor or DES Division of Developmental Disabilities notifies the Administration in writing that it refuses to sign an amendment within 60 days from the date the Administration mails the amendment, the Administration may initiate contract termination proceedings for the program contractor. For DES Division of Developmental Disabilities the refusal will be considered a grievance and administered under 9 A.A.C. 28, Article 8.~~

~~**C.** If the Administration does not receive a signed amendment or a written refusal to sign the amendment by the 60th day from the date the Administration mails the amendment, the Administration shall consider the amendment as accepted by the program contractor or DES Division of Developmental Disabilities.~~

R9-28-608. ~~Contract Suspension, Denial, Modification, Termination, or Sanction~~ Repealed

~~**A.** The Administration shall follow the suspension, denial, modification, termination, or sanction provisions in accordance with A.A.C. R9-22-405 and R9-22-406, and all references in that rule.~~

~~**B.** The Administration shall apply remedies for a NF that does not meet requirements of participation under 42 U.S.C. 1396r(h) effective August 5, 1997, and 42 CFR 488, Subpart F, effective May 17, 1999, incorporated by reference and on file with the Administration and the Office of the Secretary of State. These incorporations by reference contain no future editions or amendments.~~

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-701. Scope of the Administration's ~~liability~~ Liability

~~**A.** The Administration shall bear no liability for the provision of covered services or the completion of a plan of treatment to any member or eligible person beyond the date of termination of such individual's eligibility and enrollment.~~

~~**B.** The Administration shall bear no liability for subcontracts which the program contractor may execute with other parties for the provision of either administrative or management services, medical services, covered health care services or for any other purpose. The program contractor shall indemnify and hold the Administration harmless from any and all liability arising from these subcontracts and shall bear all costs of defense of any litigation over such liability and shall satisfy in full any judgment entered against the Administration in such connection.~~

The Administration shall bear no liability for providing covered services or completing a plan of treatment for a member beyond the date of termination of the member's eligibility.

R9-28-707. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care

~~**A.** The program contractor is responsible for providing emergency medical or acute behavioral health care to a member only until the time the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of A.R.S. § 36-2909(B) and Article 2 of this Chapter.~~

~~**B.** Subject to subsection (A), if a member cannot be transferred following stabilization to a facility that has a subcontract with a program contractor, the program contractor shall pay for all treatment that is appropriately documented, medically necessary treatment, and prior authorized in accordance with A.A.C. R9-22-705, provided to the member before the date of discharge or transfer in accordance with payment standards in A.A.C. R9-22-705.~~

~~**C.** If a member refuses transfer from a noncontracting provider institution to an institution affiliated with the member's program contractor, neither the Administration nor the program contractor shall be liable for any costs incurred subsequent to the date of refusal when:~~

~~1. Subsequent to consultation with the member's program contractor, the member continues to refuse the transfer; and~~

~~2. The member is provided and signs a written statement, before the date of transfer of liability, informing the member of the medical and financial consequences of refusing to transfer. If the member refuses to sign the written statement, a statement signed by 2 witnesses indicating that the member was informed may be substituted.~~

A contractor's liability to hospitals for the provision of emergency and subsequent care shall be under A.A.C. R9-22-709, R9-28-705, and Article 2 of this Chapter.

R9-28-710. ~~Capitation Payments to Program Contractors~~ Repealed

~~**A.** The Administration shall make all payments to a program contractor in accordance with the terms and conditions of the contract executed between the program contractor and the Administration and this Chapter.~~

~~**B.** The Administration shall pay capitation monthly to a program contractor who has met the requirements in A.R.S. § 36-2942(8).~~

~~C. The Administration shall pay a program contractor a capitated amount per member per month. Administrative costs shall be incorporated into the capitation payment amount.~~

R9-28-714. Payments to Providers
The Administration shall pay providers under A.A.C. R9-22-714. For the purposes of this Chapter, scope of services includes Article 2 of this Chapter.

R9-28-715. Specialty Contracts
The Director may negotiate specialty contracts under A.A.C. R9-22-716.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES
CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
CHILDREN'S HEALTH INSURANCE PROGRAM

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-31-101	Amend
R9-31-103	Amend
R9-31-210	Amend
R9-31-211	Amend
R9-31-213	Amend
R9-31-302	Amend
R9-31-303	Amend
R9-31-304	Amend
R9-31-306	Amend
R9-31-307	Amend
R9-31-308	Amend
R9-31-310	Amend
R9-31-503	Amend
R9-31-504	Amend
R9-31-507	Amend
R9-31-509	Amend
R9-31-511	Amend
R9-31-512	Amend
R9-31-513	Amend
R9-31-521	Amend
R9-31-522	Amend
R9-31-1205	Amend
R9-31-1207	Amend
R9-31-1403	Amend
R9-31-1404	Renumber
R9-31-1404	New Section
R9-31-1405	Renumber
R9-31-1405	New Section
R9-31-1406	Renumber
R9-31-1406	New Section
R9-31-1406	Amend
R9-31-1407	New Section
R9-31-1601	Amend
R9-31-1602	Amend
R9-31-1610	Amend
R9-31-1617	Amend
R9-31-1618	Amend
R9-31-1622	Amend
R9-31-1625	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. §§ 36-2982 and 36-2989
Implementing statute: A.R.S. §§ 36-2982, 36-2983, 36-2988, and 36-2989

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 2234, June 1, 2001

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The Administration is amending these rules for the Children's Health Insurance Program in order to conform to statutory changes in A.R.S. §§ 36-2982, A.R.S. 36-2983, A.R.S. 36-2988, and A.R.S. 36-2989 (SB 1087).

6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

The Administration has amended Articles 1, 2, 3, 5, 12, 14, and 16 to implement the statutory changes from SB 1087 (A.R.S. §§ 36-2982, 36-2983, and 36-2989). The economic impact of these provisions is nominal to minimal.

AHCCCS may experience an increase in administrative costs due to:

• Determination of eligibility for:

i. Hardship exemption and
ii. Three-month bare exemption, and

• System modifications and ongoing staff resources.

• Members, providers, DHS, and the state will benefit from the implementation of SB 1087.

a. Members will benefit due to a change in the service package:
• Multiple eye exams and prescriptive lens,
• Medically necessary non-emergency transportation,
• Unlimited behavioral health inpatient treatment and outpatient visits per year,
• Change from six month bare to three month bare, and
Possibility of hardship exemption.

b. Providers will benefit from a decrease in administrative costs. The same benefit package for Title XIX and XXI will eliminate current tracking processes.

c. DHS will have decreased administrative costs due to the deletion of direct services.

d. With the removal of the behavioral health limitations, costs are shifted from the General Fund (state monies) to the CHIP Fund (federal monies).

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200

Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: October 2, 2001

Time: 1:30 p.m.

Location: AHCCCS, Gold Room
701 E. Jefferson
Phoenix, AZ 85034

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location: Yuma City Hall, City Council chambers
180 W. 1st. St.
Yuma, AZ 85364

Parking: Parking is next door at the Armory.

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location: ALTCS: Arizona Long Term Care System
484 E. Wilcox Drive
Sierra Vista, AZ 85635

Nature: Public Hearing

Date: October 2, 2001

Time: 1:30 p.m.

Location: ALTCS: Arizona Long Term Care System
110 S. Church, Suite 3250
Tucson, AZ 85701

Nature: Video Conference Oral Proceeding

Date: October 2, 2001

Time: 1:30 p.m.

Location: ALTCS: Arizona Long Term Care System
3480 E. Route 66
Flagstaff, AZ 86004

Nature: Video Conference Oral Proceeding

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

Description	Date	Location
42 CFR 438.114	September 29, 1998	R9-31-210
42 CFR 435.910	February 28, 1986	R9-31-303
42 CFR 435.920	February 28, 1986	R9-31-303
20 CFR 416, Appendix to K	June 6, 1997	R9-31-304

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 1. DEFINITIONS

Section
R9-31-101. Location of Definitions
R9-31-103. Eligibility and Enrollment Related Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-31-210. Emergency Medical Services
R9-31-211. Transportation Services
R9-31-213. Health Risk Assessment and Screening Services

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section
R9-31-302. Applications
R9-31-303. Eligibility Criteria
R9-31-304. Income Eligibility
R9-31-306. Enrollment
R9-31-307. Guaranteed Enrollment
R9-31-308. Changes and Redeterminations
R9-31-310. Notice Requirements

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-31-503. Reinsurance
R9-31-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions
R9-31-507. Member Record
R9-31-509. Transition and Coordination of Member Care
R9-31-511. Fraud or Abuse
R9-31-512. Release of Safeguarded Information by the Administration and Contractors
R9-31-513. Discrimination Prohibition
R9-31-521. Program Compliance Audits
R9-31-522. Quality Management/Utilization Management (QM/UM) Requirements

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

Section
R9-31-1205. Scope of Behavioral Health Services
R9-31-1207. Standards for Payments

ARTICLE 14. PREMIUMS

Section
R9-31-1403. Administration Requirements for Premium Payment
R9-31-1404. Hardship Exemption
~~R9-31-1404.~~ R9-31-1405.Termination for Failure to Pay; Bad Debt
~~R9-31-1405.~~ R9-31-1406.Premiums during the Grievance and ~~Appeal~~ Request for Hearing Process

~~R9-31-1406.~~ R9-31-1407.Newborns

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section
R9-31-1601. General Requirements
R9-31-1602. General Requirements for Scope of Services
R9-31-1610. Transportation Services
R9-31-1617. Prior Authorization
R9-31-1618. Claims
R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care
R9-31-1625. Behavioral Health Services

ARTICLE 1. DEFINITIONS

R9-31-101. Location of Definitions

A. For purposes of this Article the term member shall be substituted for the term eligible person.

B. Location of definitions. Definitions applicable to ~~A.A.C. Title 9, Chapter 31~~ 9 A.A.C. 31 are found in the following.

Definition	Section or Citation
"1st-party liability"	R9-22-110
"3rd-party"	R9-22-110
"3rd-party liability"	R9-22-110
"Accommodation"	R9-22-107
"Action"	R9-31-113
"Acute mental health services"	R9-22-112
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-31-108
"Aggregate"	R9-22-107
"AHCCCS"	R9-31-101
"Ambulance"	R9-22-102
"Ancillary department"	R9-22-107
"Applicant"	R9-31-101
"Application"	R9-31-101
"ADHS"	R9-31-112
"Behavior management services"	R9-31-112
"Behavioral health paraprofessional"	R9-31-112
"Behavioral health professional"	R9-31-112
"Behavioral health service"	R9-31-112
"Behavioral health technician"	R9-31-112
"Billed charges"	R9-22-107
"Board eligible for psychiatry"	R9-31-112
"Capital costs"	R9-22-107
"Case management services"	R9-31-112
"Certified nurse practitioner"	R9-31-102
"Certified psychiatric nurse practitioner"	R9-31-112
"Child"	42 U.S.C. 1397jj
"Chronically ill"	A.R.S. § 36-2983
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-31-112
"CMDP"	R9-31-103
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contractor"	R9-31-101
"Contract year"	R9-31-101
"Copayment"	R9-22-107
"Cost avoidance"	R9-31-110
"Cost-to-charge ratio"	R9-22-107
"Covered charges"	R9-31-107
"Covered services"	R9-22-102
"CPT"	R9-22-107

"CRS"	R9-31-103
"Date of action"	R9-31-113
"Day"	R9-22-101
"Denial"	R9-31-113
"De novo hearing"	R9-31-112
"Dentures"	R9-22-102
"DES"	R9-31-103
"Determination"	R9-31-103
"Diagnostic services"	R9-22-102
"Director"	A.R.S. § 36-2981
"DME"	R9-22-102
"DRI inflation factor"	R9-22-107
~~"EAC"~~	~~A.R.S. § 36-2905.03(B)~~
~~"ELIC"~~	~~A.R.S. § 36-2905.03(C) and (D)~~
"Emergency medical condition"	42 U.S.C. 1396(v)
"Emergency medical services"	R9-22-102
"Encounter"	R9-22-107
"Enrollment"	R9-31-103
"Evaluation"	R9-31-112
"Facility"	R9-22-101
"Factor"	R9-22-101
"FPL"	A.R.S. § 36-2981
"Grievance"	R9-22-108
"Group Health Plan"	42 U.S.C. 1397jj
"GSA"	R9-22-101
"Guardian"	R9-22-103
"Head of Household"	R9-31-103
"Health plan"	A.R.S. § 36-2981
"Hearing"	R9-22-108
"Hearing aid"	R9-22-102
"Home health services"	R9-22-102
"Hospital"	R9-31-103
"ICU"	R9-22-107
"IGA"	R9-31-116
"IHS"	R9-31-116
"IHS" or "Tribal Facility Provider"	R9-31-116
"IMD"	R9-31-112
"Inmate of a public institution"	42 CFR 435.1009
"Inpatient hospital services"	R9-31-101
"Inpatient psychiatric facilities for individuals under age 21"	R9-31-112
"License" or "licensure"	R9-22-101
"Medical record"	R9-22-101
"Medical review"	R9-31-107
"Medical services"	R9-22-101
"Medical supplies"	R9-22-101
"Member"	A.R.S. § 36-2981
"Mental disorder"	R9-31-112
~~"MI/MN"~~	~~A.R.S. § 36-2901(4)(a) and (c)~~
"New hospital"	R9-22-107
"NF"	42 U.S.C. 1396r(a)
"NICU"	R9-22-107
"Noncontracting provider"	A.R.S. § 36-2981
"Occupational therapy"	R9-22-102
"Offeror"	R9-31-106
"Operating costs"	R9-22-107
"Outlier"	R9-31-107
"Outpatient hospital service"	R9-22-107
"Ownership change"	R9-22-107

"Partial care"	R9-31-112
"Peer group"	R9-22-107
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	A.R.S. § 36-2981
"Post stabilization services"	42 CFR 438.114
"Practitioner"	R9-22-102
"Pre-existing condition"	R9-31-105
"Prepaid capitated"	A.R.S. § 36-2981
"Prescription"	R9-22-102
"Primary care physician"	A.R.S. § 36-2981
"Primary care practitioner"	A.R.S. § 36-2981
"Primary care provider"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Private duty nursing services"	R9-22-102
"Program"	A.R.S. § 36-2981
"Proposal"	R9-31-106
"Prospective rates"	R9-22-107
"Prudent layperson standard"	42 U.S.C. 1396u-2
"PSP"	R9-31-103
"Psychiatrist"	R9-31-112
"Psychologist"	R9-31-112
"Psychosocial rehabilitation"	R9-31-112
"Qualified alien"	P.L. 104-193
~~"Qualifying Health Center"~~	~~A.R.S. § 36-2981~~
"Qualifying plan"	A.R.S. § 36-2981
"Quality management"	R9-22-105
"Radiology services"	R9-22-102
"Rebasing"	R9-22-107
"Redetermination"	R9-31-103
"Referral"	R9-22-101
"RBHA"	R9-31-112
"Registered nurse"	R9-31-112
"Rehabilitation services"	R9-22-102
"Reinsurance"	R9-22-107
"RFP"	R9-31-106
"Respiratory therapy"	R9-22-102
"Respondent"	R9-22-108
"Scope of services"	R9-22-102
"Screening"	R9-31-112
"SDAD"	R9-22-107
"SMI"	A.R.S. § 36-550
"Seriously ill"	R9-31-101
"Service location"	R9-22-101
"Service site"	R9-22-101
"Specialist"	R9-22-102
"Speech therapy"	R9-22-102
"Spouse"	R9-31-103
"SSI-MAO"	R9-31-103
"Sterilization"	R9-22-102
"Subcontract"	R9-22-101
"Substance abuse"	R9-31-112
"TRBHA"	R9-31-116
"Tier"	R9-22-107
"Tiered per diem"	R9-31-107
"Title XIX"	42 U.S.C. 1396
"Title XXI"	42 U.S.C. 1397jj
"Treatment"	R9-31-112

"Tribal facility"	A.R.S. § 36-2981
"Utilization management"	R9-22-105

C. General definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:
"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"Applicant" means a person who submits, or on whose behalf is submitted, a written, signed, and dated application for Title XXI benefits which has not been completed or denied.

"Application" means an official request for Title XXI benefits made in accordance with Article 3.

"Contractor" means a health plan that contracts with the Administration for the provision of hospitalization and medical care to members under the provisions of this Article or a qualifying plan.

"Contract year" means the date beginning on October 1 and continuing until September 30 of the following year.

"Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

"Seriously ill" means a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity that left untreated may result in:

Death,

Disability,

Disfigurement, or

Dysfunction.

R9-31-103. Eligibility and Enrollment Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "CMDP" means Comprehensive Medical and Dental Program.
2. "CRS" means Children's Rehabilitative Services.
3. "DES" means the Department of Economic Security.
4. "Determination" means the process by which an applicant is approved or denied for coverage.
5. "Enrollment" means the process by which a person is determined eligible for and enrolled in the program.
6. "Head of Household" means the household member who assumes the responsibility for providing eligibility information for the household unit.
7. "Household income" means the total gross amount of all money received by or directly deposited into a financial account of a member of the household income group as defined in R9-31-304.
8. "PSP" means Premium Sharing ~~Project~~ Program, ~~which is a 3-year pilot program~~ established according to A.R.S. § ~~36-2923~~ 36-2923.01.
9. "Redetermination" means the periodic review of a member's continued Title XXI eligibility.
10. "Spouse" means the husband or wife of a Title XXI applicant or household member, who has entered into a contract of marriage, recognized as valid by Arizona.
11. "SSI-MAO" means Supplemental Security Income-Medical Assistance Only.

ARTICLE 2. SCOPE OF SERVICES

R9-31-210. Emergency Medical Services

A. Emergency medical services shall be provided based on the prudent layperson standard to a member by licensed providers registered with AHCCCS to provide services as specified in A.R.S. § 36-2989.

B. The provider of emergency services shall verify eligibility and enrollment status through the Administration to determine the need for notification to a contractor or a RBHA for a member and to determine the party responsible for payment of services rendered.

C. Access to an emergency room and emergency medical services shall be available 24 hours per day, 7 days per week in each contractor's service area. The use of examining or treatment rooms shall be available when required by a physician or practitioner for the provision of emergency services.

D. Consultation provided by a psychiatrist or psychologist shall be covered as an emergency service, so long as it meets the requirements of 9 A.A.C. 31, Article 12.

E. Emergency services do not require prior authorization but providers shall comply with the following notification requirements:

1. Providers~~, nonproviders,~~ and noncontracting providers furnishing emergency services to a member shall notify the member's contractor within 12 hours of the time the member presents for services;
2. If a member's medical condition is determined not to be an emergency medical condition, as defined in Article 1 of this Chapter, the provider shall notify the member's contractor before initiation of treatment and follow the prior authorization requirements and protocol of the contractor regarding treatment of the member's nonemergent condition. Failure to provide timely notice or comply with prior authorization requirements of the contractor constitutes cause for denial of payment.

F. A provider~~, a nonprovider,~~ and a noncontracting provider shall request authorization from a contractor for post stabilization services. A contractor shall pay for the post stabilization services if:
1. The service is pre-approved by a contractor, or
2. A contractor does not respond to an authorization request within the time-frame specified in 42 CFR 438.114, as of September 29, 1998, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

R9-31-211. Transportation Services

~~**A.** Emergency ambulance services.~~
~~1. As specified in A.R.S. § 36-2989, emergency ambulance transportation services shall be a covered service for a member. Payment shall be limited to the cost of transporting the member in a ground or air ambulance:~~
~~a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs; and~~
~~b. When no other means of transportation is both appropriate and available.~~
~~2. A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed by the member's contractor if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior authorization is required for reimbursement of these transports.~~
~~3. Determination of whether transport is medically necessary shall be based upon the medical condition of the member at the time of transport.~~
~~4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure to notify the contractor may constitute cause for denial of claims.~~
~~**B.** Air ambulance services shall be covered only if:~~
~~1. The air ambulance transport is initiated upon the request of an emergency response unit, a law enforcement official, a hospital or clinic medical staff member, a physician, or a practitioner;~~
~~2. The point of pickup is inaccessible by ground ambulance, or great distances, or other obstacles are involved in getting emergency services to the member or transporting the member to the nearest hospital or other provider with appropriate facilities; and~~
~~3. The medical condition of the member requires timely ambulance service and ground ambulance service will not suffice.~~
~~**C.** Medically necessary patient transfers provided by an emergency air or ground transportation provider may be covered when a member receiving inpatient services requires transport to another level of care or requires round trip transport to another facility to obtain necessary specialized diagnostic treatment services if:~~
~~1. A member's condition is such that the use of any other method of transportation would be harmful to a member's health, and~~
~~2. Services are not available in the facility where a member is a patient.~~
~~**D.** Meals, lodging and escort services.~~
~~1 Expenses for meals and lodging for a member while en route to, or returning from, an approved and prior authorized health care service site out of a member's service area or county of residence shall be a Title XXI covered service.~~
~~2. Expenses of an escort, who may be a family household member accompanying a member out of a member's service area shall be covered if the services of the escort are ordered in writing by a member's primary care provider, attending physician or practitioner.~~
~~**E.** Limitations.~~
~~1. Expenses shall be allowed only when a member requires a covered service that is not available in the service area;~~
~~2. If a member is admitted to an inpatient facility, expenses for the escort shall be covered only when accompanying a member en route to, and returning from, the inpatient facility; and~~
~~3. A salary for an escort shall be covered if an escort is not a part of a member's family household.~~
~~**F.** Non-emergency transportation services are not covered as specified in A.R.S. § 36-2989.~~

The Administration shall provide transportation services under A.A.C. R9-22-211.

R9-31-213. Health Risk Assessment and Screening Services

A. As specified in A.R.S. § 36-2989, the following services shall be covered for a member less than 19 years of age:
1. Screening services, including:
   a. Comprehensive health, behavioral health and developmental histories;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history; and

d. Health education, including anticipatory guidance.

2. Vision services ~~as specified in A.R.S. § 36-2989~~ including:
   a. ~~Treatment for medical conditions of the eye~~ Diagnosis and treatment for defects in vision,
   b. ~~One eye examination per contract year, and~~ Eye examinations for the provision of prescriptive lenses, and
   c. Provision of ~~1 pair of~~ prescriptive lenses ~~per contract year~~.
3. Hearing services, including:
   a. Diagnosis and treatment for defects in hearing~~;~~ ,
   b. Testing to determine hearing impairment~~;~~ , and
   c. Provision of hearing aids.

B. All providers of services shall meet the following standards:
1. Provide services by or under the direction of, the member's primary care provider or dentist.
2. Perform tests and examinations in accordance with the AHCCCS Administration Periodicity Schedule.
   a. Refer members as necessary for dental diagnosis and treatment, and necessary specialty care.
   b. Refer members as necessary for behavioral health evaluation and treatment services as specified in 9 A.A.C. 31, Article 12.

C. Contractors shall meet the following additional conditions for members:
1. Provide information to members and their parents or guardians concerning services;
2. Notify members and their parents or guardians regarding the initiation of screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule.

D. Members with special health care needs shall be referred to the Children's Rehabilitative Service program.

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-31-302. Applications

A. Availability. The Administration shall make available Title XXI applications. Any person may request a Title XXI application.

B. Submission of Applications. An application shall be completed and submitted to the Administration:
1. In person,
2. By mail,
3. By fax, or
4. By other form approved by the Administration.

C. Date of application. The date of application is the date the Administration or its designee receives an application which:
1. Is signed by the person making an application,
2. Includes the name of the person for whom assistance is requested, and
3. Includes the address and telephone number of the person submitting the application.

D. Completed application.
1. The Administration shall consider an application complete when:
   a. All questions are answered,
   b. An enrollment choice is included, and
   c. All necessary verification is provided by an applicant or an applicant's representative.
2. When the application is incomplete, the Administration shall:
   a. Contact an applicant or an applicant's representative by telephone to obtain the missing information required for an eligibility determination; or
   b. Mail a ~~pending notice~~ request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the ~~notice~~ request to provide the required additional information ~~listed on the pending notice~~.

E. Eligibility determination processing time.
1. Except when there is an emergency beyond the Administration's control, the Administration shall not delay the eligibility determination beyond 30 days from the date of application when information and verification necessary to make the determination has been provided and obtained.
2. An applicant shall provide the Administration with all requested verification within 10 days from the notice date of the written request for the information. If an applicant fails to provide the requested information and fails to request an extension of the 10 day period, the Administration may deny eligibility.

F. Waiting list. If the Administration stops processing an application because the monies are insufficient as specified in R9-31-301(C)(1), the Administration shall place an applicant on a waiting list and notify the applicant. When increased funding becomes available, the Administration shall contact an applicant on the waiting list and ask the applicant to submit a new application if the original application is more than 60 days old. Spaces will be filled as a completed application is received and approved.

R9-31-303. Eligibility Criteria

Eligibility. To be eligible for the program, a person shall meet all the following eligibility requirements:

A. Age. Is under 19 years of age. A child's coverage will continue through the month in which a child turns age 19 if the child is otherwise eligible;

B. Citizenship. Is a United States citizen or a qualified alien as specified in A.R.S. § 36-2983;

C. Residency. Is a resident of the state of Arizona as specified in A.R.S. § 36-2983. An Arizona resident is a person who currently lives in Arizona and intends to remain in Arizona indefinitely;
D. Income. Meets the income requirements in R9-31-304;
E. Cost sharing. Pays the cost sharing premium amount when premiums are required as specified in A.R.S. § 36-2982;
F. Social security number. Provides a social security number or applies for one within 30 days after an applicant submits a Title XXI application as specified in A.R.S. § 36-2983. The Administration shall not deny eligibility for Title XXI if an applicant does not provide or apply for a social security number unless the sole reason the child is ineligible for Title XIX is for failure to comply with social security number requirements specified in 42 CFR 435.910 and 42 CFR 435.920 as of ~~May 29~~ February 28, 1986, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;
G. Assignment. Assigns rights to any 1st- or 3rd-party coverage of medical care as specified in 9 A.A.C. 31, Article 10;
H. Other federal program. Is not eligible for Title XIX or other federally operated or financed health care insurance program, except the Indian Health Service or a Tribal Facility as specified in A.R.S. § 36-2983;
I. Inmate of a public institution. Is not an inmate of a public institution, as specified in A.R.S. § 36-2983;
J. Patient in an institution for mental disease. Is not a patient in an institution for mental disease at the time of application, or at the time of redetermination, as specified in A.R.S. § 36-2983;
K. Other health coverage. Is not covered under:
1. An employer's group health insurance plan,
2. Family or individual health insurance, or
3. Other health insurance;

L. State health benefits. Is not a member of a family that is eligible for health benefits coverage under a state health benefit plan based on an applicant, a member, or a parent's employment with a public agency in the state of Arizona;
M. Prior health insurance coverage. Has not been covered by health insurance during the previous ~~6~~ three months unless that health insurance was discontinued due to the involuntary loss of employment or other involuntary reason as specified in A.R.S. § 36-2983. The ~~6~~ three months of ineligibility due to previous insurance coverage shall not apply to:
1. A newborn as defined in R9-31-309;
2. A Title XIX member as specified in 9 A.A.C. 22, Article 1;
~~3. An MI/MN member as specified in 9 A.A.C. 22, Article 1;~~
~~4. An EAC member as specified in 9 A.A.C. 22, Article 1;~~
~~5. An ELIC member as specified in 9 A.A.C. 22, Article 1;~~
~~6. A state funded SSI MAO non-qualified alien as specified in A.R.S. § 36-2903.03;~~
3. An applicant who is seriously or chronically ill under A.R.S. § 36-2983 and R9-31-101;
~~7.~~4. A Title XXI member who loses insurance coverage;
~~8.~~5. A CRS member; or
~~9.~~6. A Native American member receiving services from IHS or a Tribal Facility.

R9-31-304. Income Eligibility
A. Income standard. The combined gross income of the household income group members as specified in subsection (C) shall not exceed the percentage of the appropriate FPL for the Title XXI household income group size as specified in A.R.S. § 36-2981 ~~for the state fiscal year~~.
B. Countable income. The Administration shall count all income received during a month by the household income group members as specified in subsection (C) except income which is specified in subsections (D) and (E).
C. Title XXI household income group.
1. For this Section:
   a. "Child" means a person under 19 years of age or an unborn child.
   b. "Parent" means a biological, adoptive, or step parent.
2. The following related persons, when residing together, constitute a Title XXI household income group:
   a. A married couple and children of either 1 or both;
   b. An unmarried couple with a common child and other children of either 1 or both;
   c. A married couple when 1 or both are under age 19 with no children;
   d. A single parent and the single parent's children;
   e. A child who does not live with a parent; and
   f. The following persons, when living with a child:
      i. A spouse of the child;
      ii. A child of the spouse child;
      iii. A child of the child; and
      iv. The other parent of a child of the child.
3. A person who is absent from a household shall be included in the child's household income group if absent:
   a. For 30 days or less,
   b. For the purpose of seeking employment or to maintain a job,
   c. For serving in the military,

d. For an educational purpose and the child's parent claims the child as a dependent on the parent's income tax return.

D. Income disregards. When determining gross income of the household, the Administration shall disregard the following:
1. Income specified in 20 CFR ~~Part~~ 416, Appendix to K as of ~~April 1, 1997~~ June 6, 1997, which is incorporated by reference and on file with the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;
2. Income paid according to federal law that prohibits the use of the income when determining eligibility for public benefits;
3. Money received by a member as the result of the conversion of an asset;
4. Income tax refunds; and
5. For a self-employed household member, the Administration shall count only the net income of that self-employment, after deducting the expenses of producing that income, but not income taxes or capital investments.

E. Regular infrequent income. Income that is received regularly but less often than monthly shall be pro-rated over the number of months between payments with only the pro-rated monthly amount.

R9-31-306. Enrollment

A. Selection choices.
1. Except as provided in subsections (A)(3), (4), and (5), at the time of application, an applicant shall select from the following enrollment choices:
   a. A contractor which includes a ~~health plan~~ contractor or a qualifying plan as defined in A.R.S. § 36-2981, or
   ~~b. A qualifying health center as specified in A.R.S. § 36-2907.06, or~~
   ~~c.~~b. The IHS as specified in A.R.S. § 36-2982. If a member is enrolled with the IHS, a member may elect to receive covered services from a participating 638 Tribal Facility.
2. Except as provided in subsections (A)(3), (4), and (5), coverage shall not begin until a Title XXI enrollment choice is made.
3. The Administration shall enroll a member with CMDP when a member is a foster care child according to A.R.S. § 8-512.
4. When a Title XIX member becomes ineligible for Title XIX and DES determines a child eligible for Title XXI with no break in coverage,
   a. The Title XXI child shall remain enrolled with the Title XIX contractor; and
   b. The Administration shall send the Title XXI member a notice explaining the member's right to choose as specified in subsection (A)(1).
5. When a person applies for Title XIX through DES and DES determines a child ineligible for Title XIX but eligible for Title XXI, the Administration shall enroll the child for Title XXI as follows:
   a. If a Title XIX ~~health plan~~ contractor pre-enrollment choice is pending at the time the Administration receives the Title XXI approval from DES, the Administration may:
      i. Enroll a child with the Title XIX ~~health plan~~ contractor, and
      ii. Notify the member of the member's enrollment and provide the member an opportunity to select an enrollment choice as specified in subsection (A)(1).
   b. If there is no pending Title XIX choice at the time the Administration receives the Title XXI approval from DES, the Administration shall pend the Title XXI decision and obtain a choice from the member as specified in subsection (A)(1).

B. Effective date of initial enrollment.
1. For eligibility determinations completed by the 25th day of the month, enrollment shall begin on the 1st day of the month following the determination of eligibility.
2. For eligibility determination completed after the 25th day of the month, enrollment shall begin on the 1st day of the 2nd month following the determination of eligibility.

C. Enrollment changes.
1. If a member moves from 1 GSA to another GSA during the period of enrollment, enrollment changes will occur as follows:
   a. If a member's current enrollment choice is available in a member's new GSA, a member will remain enrolled with the member's current enrollment choice.
   b. If a member's current enrollment choice is not available in the new GSA, a member shall:
      i. Remain enrolled with the current enrollment choice. The current enrollment choice may limit services to emergency services outside the GSA as specified in R9-31-201.
      ii. Select from the enrollment choices provided in R9-31-306(A)(1) that are available in the new GSA. Once a new choice is made, a member shall be enrolled with the new choice effective with the date the Administration processes the member's enrollment choice. Covered services shall be available on the date of the enrollment change.
2. A member may change a member's enrollment choice:
   a. During a member's annual enrollment choice period,
   b. At any time from:
      i. IHS to a contractor as specified in subsection (A)(1) of this Section;
      ii. A contractor to IHS,

iii. IHS to a qualifying health center as specified in subsection (A)(1) of this Section,
iv. A qualifying health center to IHS,
v. A qualifying health center to a contractor.

c. When a member is no longer a foster care child as specified in subsection (A)(3) of this Section.

3. Except for subsection (C)(2)(c) of this Section, the effective date of the new enrollment choice is the date the Administration processes the enrollment choice. The effective date of the enrollment change from CMDP to a Title XXI choice as specified in subsection (A)(1) of this Section, shall be the 1st of the following month.

D. Annual enrollment choice period. A member shall have the opportunity to change enrollment within at least 12 months from the date of initial enrollment and then 12 months following the last time a member made an enrollment choice or had the opportunity to make an enrollment choice.

E. Health Insurance Portability and Accountability Act of 1996. As specified in A.R.S. § 36-2982, a Title XXI member who has been disenrolled shall be allowed to use enrollment in the Title XXI program as creditable coverage as defined in A.R.S. § 36-2984.

R9-31-307. Guaranteed Enrollment

A. Guaranteed Enrollment. A child who has been determined eligible for Title XXI will be guaranteed a 1-time, 12-month period of continuous coverage unless a child:

1. Attains age 19,
2. Is no longer a resident of the state,
3. Is an inmate of a public institution,
4. ~~Is enrolled with Title XIX,~~
~~5.~~4. Is determined to have been ineligible at the time of approval,
~~6.~~5. Obtains private or group health coverage,
~~7.~~6. Is adopted and the new household does not meet the qualifications of this program,
~~8.~~7. Is a patient in an institution for mental diseases,
~~9.~~8. Whereabouts is unknown, or
~~10.~~9.A child's parent or legal guardian:
   a. Does not pay cost sharing premium amount when premiums are required as specified in A.R.S. § 36-2982 and as specified in this Chapter,
   b. Voluntarily withdraws from the program, or
   c. Fails to cooperate in meeting the requirements of the program.

B. The 12-month guaranteed period will begin with the month an applicant is initially enrolled.

R9-31-308. Changes and Redeterminations

A. Reporting Changes. A member or a member's parent or guardian shall report the following changes to the Administration:

1. Any ~~change~~ increase in income that will begin or continue into the following month,
2. Any change of address,
3. The addition or departure of a household member,
4. Any health coverage under private or group health insurance,
5. Employment of a member or a parent with a state agency, and
6. Incarceration of a member.

B. Verification. If required verification is needed and requested as a result of a change specified in subsection (A) of this Section to determine the impact on eligibility and is not received within 10 days, the Administration may discontinue eligibility for a member unless a member is within the guaranteed eligibility period as specified in R9-31-307.

C. Redeterminations. If no change is reported, the Administration shall initiate redetermination no later than the end of the 12th month after the effective date of eligibility, or the completion of the most recent redetermination application, whichever is later.

D. Termination. If the Administration determines that a child no longer meets the eligibility criteria, or a child, a parent, or a guardian fails to respond or cooperate with the redetermination of eligibility, coverage will be terminated.

R9-31-310. Notice Requirements

A. Applications. Upon completion of a determination of eligibility or ineligibility for any child in the household, the Administration shall issue a written notice to an individual who initiated the application. This notice shall include a statement of the intended action, an explanation of a person's hearing rights as specified in 9 A.A.C. 31, Article 8 and:

1. If approved, the notice shall contain the name and effective date of eligibility for each approved applicant;
2. If denied, the notice shall contain:
   a. The name of each ineligible applicant,
   b. The effective date of the denial,
   c. The reasons for ineligibility including appropriate income calculations and income standard when the reason for the denial is based on excess income,
   d. The legal authority supporting the reason for ineligibility, and

e. Where the references are physically located for review.

B. Terminations.

1. When the Administration proposes a termination of Title XXI eligibility, the Administration shall provide a member with:
   a. Advance notice at least 10 days before the effective date of the adverse action except as provided in subsection (B)(1)(b).
   b. Adequate notice no later than the date of adverse action when a member:
      i. Voluntarily withdraws and indicates an understanding of the results of the action,
      ii. Becomes an inmate of a public institution as specified in R9-31-303(I),
      iii. Dies and the Administration has verification of the death,
      iv. Has whereabouts that are unknown and the Administration's loss of contact is confirmed by returned mail from the post office with no forwarding address, or
      v. Is approved for Title XIX.
2. In addition to the requirements listed in subsection (A)(2), the termination notice shall include an explanation of a member's right to continued Title XXI coverage pending ~~appeal~~ a request for hearing as provided in 9 A.A.C. 31, Article 8. A premium paying member has the right to continued Title XXI coverage pending ~~an appeal~~ a request for hearing if the member meets the requirements specified in this Chapter.

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-31-503. Reinsurance

A. Contractor-acquired reinsurance. As specified in A.R.S. § 36-2988, a contractor may obtain reinsurance for coverage of prepaid capitated members. A contractor shall not obtain reinsurance to reduce liability below 25% of the applicable deductible level during any Title XXI contract year. This limitation does not apply to reinsurance obtained by a contractor to cover the cost of services provided by noncontracting providers ~~and nonproviders~~ to a member under emergency circumstances.

B. Administration reinsurance. For purposes of the Administration's reinsurance program, the insured entity shall be a prepaid plan with which the Administration contracts. Only costs incurred during the contract year in which a member is enrolled with a contractor qualify for reinsurance. Any movement of a member from membership with 1 contractor to membership with another contractor shall be cause for resetting the deductible level unless resetting is waived by the Administration.

C. Encounter submission. A contractor shall prepare, review, verify, certify, and submit, encounters for consideration to the Administration.

1. The contractor shall certify that the services listed were actually rendered, medically necessary, and within the scope of Title XXI benefits.
2. The contractor shall submit encounters in the format prescribed by the Administration.
3. The contractor shall initiate and evaluate an encounter for probable 1st- and 3rd-party liability before submitting the encounter for reinsurance consideration to the Administration, unless the encounter involves underinsured or uninsured motorist liability insurance, 1st- and 3rd-party liability insurance, or a tort-feasor.
4. The Administration shall not consider a reinsurance claim for payment unless the claim is received by the AHCCCS Claims Administration not later than 12 months after the date of service.

D. Encounter processing. The Administration shall process reinsurance associated or related encounters submitted by a contractor.

1. The Administration shall accept for processing only those encounters that are submitted directly by a Title XXI contractor and that comply with the conditions in subsections (B), (C), (E), and (F).
2. The Administration shall establish and maintain separate records of all reinsurance cases established and all payments and case reviews made to the contractor as a result of these cases.
3. The Administration shall subject a contractor to utilization of services and other evaluative reviews of care provided to a member that result in a reinsurance case.

E. Payment of reinsurance cases. The Administration shall reimburse a contractor for costs incurred in excess of the applicable deductible level calculated according to the provisions of A.A.C. R9-22-703.

F. The Administration may limit reinsurance reimbursement to a lower or alternative level of care if the Director or designee determines that the less costly alternative could and should have been used by the contractor. A contractor whose reinsurance case is reduced or denied shall be notified in writing by the Administration. The notification shall include the cause for reduction or denial and describe the applicable grievance and ~~appeal~~ request for hearing process available under 9 A.A.C. 31, Article 8.

G. The Administration or its contractors may arrange special contractual reinsurance terms for catastrophic cases. Catastrophic cases include, but are not limited to organ and bone marrow transplants (excluding kidney and cornea transplants which are covered under regular reinsurance), and hemophiliac cases. The contractor shall notify the Administration when

a member is identified for possible reimbursement of Title XXI-approved catastrophic cases. The determination of whether a case or type of case is catastrophic shall be made by the Director based on the following criteria:

1. Severity of medical condition, including prognosis; and
2. Average cost or average length of hospitalization and medical care, or both, in Arizona for the type of case under consideration.

R9-31-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions

A. A contractor or the contractor's marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure Title XXI enrollment. A contractor may make Title XXI applications available, but shall not assist with the completion of an application or steer an applicant into a particular contractor. Any marketing solicitation offering a benefit, good, or service, in excess of the covered services in 9 A.A.C. 31, Article 2 shall be deemed an inducement.

B. A marketing representative shall not misrepresent itself, the contractor represented, or the Title XXI program, through false advertising, false statements, or in any other manner to induce a member of another contracting entity to enroll in the represented contractor. The Administration shall deem violations of this subsection to include, but not be limited to, false or misleading claims, inferences, or representations that:

1. A member will lose benefits under the Title XXI program or any other health or welfare benefits to which the member is legally entitled, if the member does not enroll in the represented contractor;
2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any contractor other than the contractor with whom they are employed, or by whom they are reimbursed; and
3. The represented contractor is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the ~~health plan~~ contractor and the Administration.

C. A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

D. The Administration shall hold a contractor responsible for the performance of any marketing representative, subcontractor or agent, program, or process under its employ or direction and shall make the contractor subject to the contract sanctions in this Chapter.

R9-31-507. Member Record

As specified in A.R.S. § 36-2986, a contractor shall maintain a member service record that contains at least the following for each member:

1. Encounter data,
2. Grievances and ~~appeals~~ requests for hearing,
3. Any informal complaints, and
4. Service information.

R9-31-509. Transition and Coordination of Member Care

A. As specified in A.R.S. § 36-2986, the Administration shall coordinate and implement disenrollment and re-enrollment procedures when a member's change of residency requires a change in contractor.

B. A contractor shall assist in the transition of members to and from other contractors.

1. Both the receiving and relinquishing contractor shall:
   a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. A contractor's policies and procedures regarding transition of members are subject to review and approval by the Administration;
   b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
   c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions, are receiving ongoing services, or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
3. The relinquishing contractor shall forward medical records and other materials to the receiving contractor. The cost of reproducing and forwarding medical records and other materials shall be borne by the relinquishing contractor;
4. Within the contract-specified timelines, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
   a. Information regarding the contractor's providers,
   b. Emergency numbers, and
   c. Instructions about how to obtain new services.

C. A contractor shall not use a county or ~~nonprovider~~ noncontracting provider health resource alternative that diminishes the contractor's contractual responsibility or accountability for providing the full scope of covered services. Referrals made to other health agencies by a contractor, primarily to reduce expenditures incurred by the contractor on behalf of its members, may result in the application of sanctions described in this Chapter.

D. A contractor may transfer a member as specified in A.R.S. § 36-2986, from a noncontracting provider to a contracting provider's facility as soon as a transfer will not be harmful to the member's health as authorized by the member's primary care provider or the contractor's Medical Director. A member's plan shall pay the cost of transfer.

R9-31-511. Fraud or Abuse

As specified in A.R.S. §§ 36-2986 and 36-2992, a contractor, provider, or ~~nonprovider~~ noncontracting provider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

R9-31-512. Release of Safeguarded Information by the Administration and Contractors

A. The Administration, a contractor, a provider, and a noncontracting provider shall safeguard information concerning an applicant or member which includes the following:
1. Name and address;
2. Social Security number;
3. Social and economic conditions or circumstances;
4. Agency evaluation of personal information;
5. Medical data and services, including diagnosis and history of disease or disability;
6. State Data Exchange (SDX) tapes from the U.S. Social Security Administration; and
7. Information system tapes from the Arizona Department of Economic Security.

B. The restriction upon disclosure of information does not apply to:
1. Summary data,
2. Statistics,
3. Utilization data, and
4. Other information that does not uniquely identify an applicant or member.

C. The Administration, a contractor, a provider, and a noncontracting provider shall use or disclose information concerning an applicant or member only under the conditions specified in subsection (D), (E), and (F) and only to:
1. The person concerned,
2. Individuals authorized by the person concerned, and
3. Persons or agencies for official purposes.

D. Safeguarded information shall be viewed by or released for only:
1. An applicant;
2. A member; or
3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
   a. An Administration employee or its authorized representative, or responsible caseworker is present during the examination of the eligibility record; or
   b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.
4. A purpose as specified in R9-31-512(F).

E. An eligibility case record, medical record, and any other Title XXI-related confidential and safeguarded information regarding a member, applicant, or unemancipated minor shall be released to individuals authorized by the member, applicant, or parent of an unemancipated minor only under the following conditions:
1. Authorization for release of information is obtained from the member, applicant, or designated representative;
2. Authorization used for release is a written document, separate from any other document, that specifies the following information:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom release is authorized;
   c. The period of time for which the authorization is valid, if limited; and
   d. A dated signature of the ~~adult and~~ mentally competent member, applicant, or designated representative. If the member~~,~~ or applicant is ~~a~~ an unemancipated minor, the dated signature of a parent, custodial relative, or designated representative shall be required. If the member, or applicant is mentally incompetent, authorization shall be according to A.R.S. § 36-509;
3. If ~~an appeal~~ a request for hearing or grievance is filed, the member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.

F. Release of safeguarded information to individuals or agencies for official purposes:
1. Official purposes directly related to the administration of the Title XXI program include:
   a. Establishing eligibility and premiums, as applicable;
   b. Determining the amount of medical assistance;

c. Providing services for members;
d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the Title XXI program;
e. Performing evaluations and analyses of Title XXI operations;
f. Filing liens on property, as applicable;
g. Filing claims on estates, as applicable; and
h. Filing, negotiating, and settling medical liens and claims.

2. For official purposes related to the administration of the Title XXI program and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant or member:
a. Employees of the Administration;
b. Employees of the U.S. Social Security Administration;
c. Employees of the Arizona Department of Economic Security;
d. Employees of the Arizona Department of Health Services;
e. Employees of the U.S. Department of Health and Human Services;
f. Employees of contractors, providers, and subcontractors;
g. Employees of the Arizona Attorney General's Office; or
h. ~~Qualifying community health centers as specified in A.R.S. § 36-2907.06 and hospitals~~ Hospitals as specified in A.R.S. § 36-2907.08.

3. Law enforcement officials:
a. Information may be released to law enforcement officials without the applicant's, or member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the Title XXI program.
b. Medical record. The Administration and contractors shall release safeguarded information contained in a member's medical record to law enforcement officials without the member's consent in situations of suspected of fraud or abuse against the Title XXI program.
c. A contractor shall release the medical record or information in the case record or other information developed in case management or utilization management operations without the member's written or verbal consent, for the purpose of an investigation, prosecution, or similar criminal proceeding not in connection with the Administration, only if the law enforcement official requesting the information has statutory authority to obtain the information.

4. The Administration may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2986, without the consent of the applicant or member.
5. Providers shall furnish requested records to the Administration and its contractors at no charge.

G. The holder of a medical record of a former applicant or member shall obtain written consent from the former applicant or member before transmitting the medical record to a primary care provider.

H. Subcontractors are not required to obtain written consent from a member before transmitting the member's medical records to a physician who:
1. Provides a service to the member under subcontract with the program contractor,
2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature, and
3. Provides a service under the contract.

R9-31-513. Discrimination Prohibition

A. A contractor, provider, and ~~nonprovider~~ noncontracting provider shall not discriminate against a member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability in accordance with Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C. 2000d, and rules and regulations promulgated according to, or as otherwise provided by law. For the purpose of providing covered service under contract according to A.R.S. Title 36, Ch. 29, discrimination includes, but is not limited to, the following if done on the grounds of the member's race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability:
1. Denying or providing a member any covered service or availability of a facility;
2. Providing to a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other Title XXI members under contract, other public or private members, or the public at large except when medically necessary;
3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
4. Assigning to a member times or places for the provision of services that are different from those assigned to other Title XXI members under contract.

B. A contractor shall take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability, except where medically indicated.

R9-31-521. Program Compliance Audits

A. As specified in A.R.S. § 36-2986, the Administration shall conduct a program compliance audit of a contractor at least once every 12 months during the term of its contract with the contractor. Unless the Administration determines that advance notice will render a program compliance audit less useful, a contractor will be notified approximately 3 weeks in advance of the date of an onsite program compliance audit. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit, either in conjunction with the program compliance audit or as part of an unannounced inspection program.

B. A review team may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with members, physicians, and other health professionals and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services to the ~~health plan~~ contractor. The examination may include, but not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the ~~health plan~~ contractor, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

R9-31-522. Quality Management/Utilization Management (QM/UM) Requirements

A. As specified in A.R.S. §§ 36-2986 and 36-2990, a contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.

B. A contractor shall:

1. Submit a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
   a. Monitoring and evaluating the types of services,
   b. Identifying the numbers and costs of services provided,
   c. Assessing and improving the quality and appropriateness of care and services,
   d. Evaluating the outcome of care provided to members, and
   e. Determining the steps and actions necessary to improve service delivery.
2. Submit the QM/UM plan on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan before implementation;
3. Receive approval from the Administration before implementing the initial QM/UM plan;
4. Ensure that a QM/UM committee operates under the control of the contractor's medical director, and includes representation from medical and executive management personnel. The committee shall:
   a. Oversee the development, revision and implementation of the QM/UM plan; and
   b. Ensure and allocate qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities.
5. Ensure that the QM/UM activities include at least:
   a. Prior authorization for non-emergency or scheduled hospital admissions;
   b. Concurrent review of inpatient hospitalization;
   c. Retrospective review of hospital claims;
   d. Program and provider audits designed to detect over or under utilization, service delivery effectiveness, and outcome;
   e. Medical records audits;
   f. Surveys to determine satisfaction of members;
   g. Assessment of the adequacy and qualifications of the contractor's provider network;
   h. Review and analysis of QM/UM data; and
   i. Other activities necessary to improve the quality of care and the efficient, cost effective delivery and utilization of services.

C. A member's primary care provider shall maintain medical records that:

1. Are detailed and comprehensive and identify:
   a. All medically necessary services provided to the member by the contractor and the subcontractors, and
   b. All emergency services provided by ~~nonproviders~~ noncontracting providers for a member.
2. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data,

3. Facilitate follow-up treatment, and
4. Permit professional medical review and medical audit processes.

D. A subcontractor or its designee shall forward medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services, within 30 days following termination of a contract between the subcontractor and the contractor.

E. The Administration shall monitor contractors and their providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor QM/UM plan.
1. A contractor and its providers shall cooperate with the Administration in the performance of its QM/UM monitoring activities, and
2. A contractor and its providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-31-1205. Scope of Behavioral Health Services

A. Inpatient behavioral health services. The following inpatient services shall be covered subject to the limitations and exclusions in this Article.
1. Inpatient behavioral health services include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment. The behavioral health service shall be provided under the direction of a physician in:
   a. A general acute care hospital; or
   b. An inpatient psychiatric facility for a person under 21 years of age, licensed as a psychiatric hospital, or a residential treatment center, licensed as a Level I Psychiatric Facility, and accredited by an AHCCCS-approved accrediting body as specified in contract and as authorized by federal law and regulations.
2. Inpatient service limitations:
   a. Inpatient services, other than emergency services specified in this Section, shall be prior authorized.
   b. Inpatient services shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services ~~and the services do not count toward the 30-day 30- visit annual limitation~~:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant as defined in this Article, or
      iv. A psychologist.
   c. The following services may be billed independently if prescribed by a provider specified in R9-31-1205(B)(1)(b) for a member residing in a residential treatment center:
      i. Laboratory,
      ii. Radiology, and
      iii. Psychotropic medications and medication monitoring and medication adjustment.
   d. Title XXI funding for IMD inpatient services is available only to a member who is under 19 years of age. ~~Title XXI funding shall not exceed 30 days inpatient care after an eligibility determination.~~ A member cannot be in an IMD at the time of application or at the time of redetermination.
   ~~e. Inpatient services are limited to a maximum of 30 days per contract year.~~

B. Partial care. The following partial care services shall be covered subject to the limitations and exclusions in this Article.
1. Partial care shall be provided as either a basic or intensive level of care to:
   a. Meet a member's need for behavioral health treatment, and
   b. Prevent placing a member in a higher level of care or a more restrictive environment.
      i. Basic partial care services shall be provided as specified in 9 A.A.C. 20.
      ii. Intensive partial care services shall be provided as specified in 9 A.A.C. 20.
2. Partial care service limitations. All services shall be included in the partial care reimbursement rate, except the following practitioners may bill independently:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant as defined in this Article, and
   d. A psychologist.

~~3. Partial care services count toward the 30-day limitation during each contract year. Each full day of partial care, basic or intensive, counts as 1/2 day of inpatient care. Each 1/2 day of partial care, basic or intensive, counts as 1/4 day of inpatient care.~~

~~4.~~3. Partial care service exclusions. Vocational activities, school attendance, and educational hours shall not be included as a basic or intensive partial care service and shall not be billed concurrently with these services.

C. Outpatient services. The following outpatient services shall be covered subject to the limitations and exclusions in this Article.
1. Outpatient services shall include the following:
   a. Screening once every 6 months provided by a behavioral health professional or a behavioral health technician;
   b. Evaluation provided by a behavioral health professional;
   c. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician under the clinical supervision of a behavioral health professional;
   d. Behavior management provided by a behavioral health professional, a behavioral health technician, or a behavioral health paraprofessional; and
   e. Psychosocial rehabilitation provided by a behavioral health professional, a behavioral health technician, or a behavioral health paraprofessional.
2. Outpatient service limitations:
   a. The following practitioners may bill independently:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant as defined in this Article, and
      iv. A psychologist.
   b. Other behavioral health professionals, behavioral health technicians, and behavioral health paraprofessionals not specified in subsection (C)(2)(a) shall be employed by, or contracted with, an AHCCCS-registered behavioral health agency.
   ~~c. The total number of all outpatient services shall not exceed a maximum of 30 visits during each contract year. Screening performed once every 6 months shall not count toward the 30-visit maximum.~~
   ~~d. Each outpatient service except group therapy or group counseling shall count as 1 visit. Each group therapy or group counseling service shall count as 1/2 a visit.~~

D. Behavioral health emergency services.
1. An RBHA shall ensure that behavioral health emergency services are provided by qualified personnel specified in R9-31-1206. The emergency services shall be available 24 hours per day, 7 days per week in the RBHA's service area in emergency situations where a member is a danger to self or others or is otherwise determined to be in need of immediate unscheduled behavioral health services. Behavioral health emergency services may be provided on either an inpatient or outpatient basis.
2. A ~~health plan~~ contractor shall provide behavioral health emergency services on an inpatient basis not to exceed 3 days per emergency episode and 12 days per contract year, for a member not yet enrolled with an RBHA.
3. An inpatient emergency service provider shall verify the eligibility and enrollment of a member through the Administration to determine the need for notification to a ~~health plan~~ contractor or an RBHA and to determine the party responsible for payment of services under Article 7.
4. Behavioral health emergency service limitations:
   a. An emergency behavioral health service does not require prior authorization. The provider must, however, comply with the notification requirements specified in R9-31-210.
   b. A behavioral health service for an unrelated condition requires diagnosis and treatment shall be prior authorized by an RBHA.
   c. Inpatient service limitations specified in subsection (B) of this Section shall apply to emergency services provided on an inpatient basis.
   ~~d. Emergency or crisis behavioral health services provided on an outpatient basis by a psychiatrist, a certified psychiatric nurse practitioner, a physician assistant, or a psychologist shall not count toward the outpatient service limitations specified in this Section.~~

E. Other behavioral health services. The following services are covered but are not included in the visit limitations:
1. Case management as defined in R9-31-112;
2. Laboratory and radiology services for behavioral health diagnosis and medication management;
3. Psychotropic medication and related medication included in a ~~health plan's~~ contractor's or ~~an~~ a RBHA's formulary; and
4. Medication monitoring, administration, and adjustment for psychotropic medication and related medications.

F. Transportation services. Emergency transportation shall be covered for a behavioral health emergency specified in R9-31-211. Emergency transportation is limited to behavioral health emergencies.
~~1. Emergency transportation shall be covered for a behavioral health emergency specified in R9-31-211. Emergency transportation is limited to behavioral health emergencies.~~
~~2. Non-emergency transportation for a behavioral health service is excluded.~~

R9-31-1207. Standards for Payments

A. Payment to ADHS. ADHS shall receive a monthly capitation payment, based on the number of Title XXI members at the beginning of each month. ADHS administrative costs shall be incorporated into the capitation payment.

B. Claims submissions.
1. ADHS shall require all contracted service providers to submit clean claims no later than the time-frame specified in the ADHS contract with the Administration.
2. A claim for emergency inpatient services for a member not yet enrolled with an RBHA shall be submitted to a ~~health plan~~ contractor by a provider and shall comply with the time-frames and other applicable payment procedures in Article 7.

C. Prior authorization. Payment to a provider for services or items requiring prior authorization may be denied if prior authorization is not obtained from the Administration, an RBHA, or a ~~health plan~~ contractor as specified in R9-31-705.

ARTICLE 14. PREMIUMS

R9-31-1403. Administration Requirements for Premium Payment

A. Administration requirements for premium paying members.
1. Prepayment of the initial premium is not required for initial enrollment in the program.
2. The monthly premium payment is due on the 15th day of the month of coverage.
3. A payment is considered received when the Administration receives it, evidenced by the Administration's date stamp.
4. If the Administration does not receive the payment by the 15th day of the month, it is considered late.
5. Payments shall first be applied to any debt owed. Any remaining amounts shall be applied to the next month's premium charge.
6. If payment for a month is not received in full by the last working day of the month following the due date, the Administration shall include the following information with the premium billing statement:
   a. Past and current due amounts;
   b. Right to request a hardship exemption under R9-31-1404 including the required process for requesting the hardship exemption; and
   c. Right to request review of payment record when the member believes the Administration to be in error.

~~6.~~7. ~~If payment for a month is not received in full by the 15th day of the following month, the~~ The Administration shall send a 10-day adverse action notice proposing termination to the head of household as specified in R9-31-310(B)~~.~~ if the head of household:
   a. Does not pay the past and current due amounts by the 15th of the month, and/or
   b. Submits a request for exemption of disenrollment requirement which is denied.

~~7. If the Administration receives the late payment in full before the effective date of the termination, benefits will be continued, otherwise, services shall end on the effective date.~~

8. The Administration shall continue benefits and rescind the adverse action notice if one of the following occurs:
   a. Approval of the hardship exemption under R9-31-1404 for both months,
   b. Approval of the hardship exemption under R9-31-1404 for one month and receipt of payment for one month, or
   c. Receipt of the late payment in full before the effective date of the termination.
9. The Administration shall terminate the benefits on the effective date if no action as described in subsection (A)(8) occurs.

B. Premium submission by member.
1. A member shall pay the premium in the form of a:
   a. Cashier's check,
   b. Personal check, or
   c. Money order.
2. The Administration may decline to accept a personal check when:
   a. The member has previously paid with a personal check that was returned to the Administration because of insufficient funds, or
   b. The check is to pay for continued services during the grievance and ~~appeal~~ request for hearing process as specified in ~~R9-31-1405~~ R9-31-1406.
3. A member may pay premiums in advance.
4. When a member pays for more than 1 month at a time and is subsequently determined ineligible for the KidsCare program, the Administration shall reimburse the member for any months of coverage not used except as specified in ~~R9-31-1405~~ R9-31-1406.

R9-31-1404. Hardship Exemption

A. Definitions. The following definitions apply to this Section:
1. "Major expense" means the expense is more than 10 percent of the household's countable income under R9-31-304.
2. "Medically necessary" means as defined in A.A.C. R9-22-101.

B. Hardship exemption. The Administration shall grant a hardship exemption to the disenrollment requirements under A.R.S. § 36-2982 for a household who:
1. Is no longer able to pay the premium due to one of the hardship criteria in subsection (C), and
2. Submits a written request for a hardship exemption and provides all necessary written verification at the time of request.

C. Hardship criteria. The Administration shall consider the following hardship criteria:
1. Medically necessary expenses or health insurance premiums that:
   a. Are not covered under Medicaid or other insurance and
   b. Exceed 10 percent of the household's countable income under R9-31-304;
2. Unanticipated major expense, related to the maintenance of shelter or transportation for work;
3. A combination of medically necessary and unanticipated major expenses in this Section that exceed 10 percent of the household's countable income under R9-31-304; or
4. Death of a household member.

D. Written hardship exemption request and verification. The Administration must receive the written request and verification of exemption eligible criteria by the 10th day of the month in which the household receives the billing statement containing the current and past due premium notice.

E. Notification. The Administration shall notify the head of household concerning the approval or denial of the request for exemption and discontinuance under R9-31-310, 10 days prior to the end of the month in which the request was received.

F. Request for hearing. The head of household may request a hearing concerning the termination and denial of exemption under R9-31-802.

~~R9-31-1404.~~ R9-31-1405. Termination for Failure to Pay; Bad Debt

A. Missed payments. If a member's coverage is terminated because of 2 consecutive months with unpaid premiums, the member shall not be reenrolled until all premiums are paid.

B. Termination and reenrollment. A member who is terminated from the program for failure to pay may reapply and be reenrolled as soon as full payment is made. There is no limit to the number of times a member shall be terminated from the program for failure to pay and be reenrolled based on full payment. The Administration shall not impose an extended penalty for failure to pay.

C. Debt. When the member is terminated from the program for failure to pay the required premiums, payment of the unpaid amount is the responsibility of the head of the household. If the household separates at a later time, the debt remains the responsibility of the original head of the household. Nobody in the household shall be reenrolled in the program until all premiums are paid in full.

~~R9-31-1405.~~ R9-31-1406. Premiums during the Grievance and ~~Appeal~~ Request for Hearing Process

A. Process. Except as otherwise specified in this Chapter, all Title XXI grievances and ~~appeals~~ requests for hearing relating to an adverse action~~, decision, or policy~~ shall be processed according to the standards set by the Administration in 9 A.A.C. 31, Article 8, and as specified in contract with contractors and provider agreements.

B. Filing ~~an appeal~~ a request for hearing. A member filing ~~an appeal~~ a request for hearing because of a discontinuance of eligibility and who requests to continue ~~services~~ benefits during the ~~appeal~~ hearing process will pay ~~3 full months of premiums in advance~~ a one month premium in advance to the Administration no later than the effective date of the adverse action. A member must continue to pay the premium by the designated due date each month during the request for hearing process in order to continue benefits. A member who fails to pay ~~3 full months of~~ the premiums ~~in advance~~ may still request a hearing as specified in 9 A.A.C. 31, Article 8, but services shall not be continued pending the ~~appeal~~ hearing process.

C. Payment for continued ~~services~~ benefits pending ~~appeal~~ hearing. A member paying a premium to continue benefits during ~~an appeal~~ a hearing process shall pay ~~3 months of premiums~~ each month by:
1. Certified check, or
2. Money order.

D. Non-refundable premium. The Administration shall not refund any portion of the ~~advance~~ premiums paid.
1. If a member's appeal is denied, any remaining ~~advance~~ premium paid shall be applied toward the cost to the system.
2. If a member's appeal is upheld, any remaining ~~advance~~ premium paid shall be applied to the next month's premium charge.

~~R9-31-1406.~~ R9-31-1407.Newborns

Newborns. All deemed newborns shall be enrolled immediately upon receiving notification of the child's birth. Upon enrollment, the household's premium may be redetermined.

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1601. General Requirements

A. R9-31-1601 through R9-31-1624 apply to the acute care services provided to an enrolled member by IHS, a Tribal Facility, or a referral provider. R9-31-1618 through R9-31-1622 and R9-31-1625 apply to behavioral health services provided by the IHS, a Tribal Facility, RBHA or TRBHA.

B. As specified in A.R.S. § 36-2982, the Administration shall administer the program subject to the limitations on funding specified in A.R.S. § 36-2985.

C. As specified in A.R.S. § 36-2986, the Director has full operational authority to adopt rules or to use the appropriate rules adopted for this Article.

D. A Native American who is eligible for Title XXI may receive covered acute care services specified in this Article from:
1. An IHS Area Office as specified in A.R.S. § 36-2982 which has a signed IGA with the Administration,
2. A Tribal Facility as specified in A.R.S. § 36-2982,
3. A contractor which includes a health plan or a qualifying plan as defined in A.R.S. § 36-2981, or
4. A qualifying health center as specified in A.R.S. § 36-2907.06.

E. The IHS and a Tribal Facility shall comply with:
1. Federal and state law;
2. The IGA, if applicable; and
3. The appropriate rules as specified in this Chapter.

F. An individual or an entity that provides covered services for the IHS or a Tribal Facility shall be a registered provider who meets the appropriate certification standards established by the Administration. A provider shall be responsible for:
1. Supervising, coordinating, and providing initial and primary care to the member;
2. Initiating referrals for specialty care;
3. Maintaining continuity of member care; and
4. Maintaining an individual medical record for each assigned member.

G. The IHS and a Tribal Facility shall maintain medical records that:
1. Conform to professional medical standards and practices for documentation of medical, diagnostic and treatment data;
2. Include a detailed record of:
   a. All medically necessary services provided to a member by the IHS or a Tribal Facility,
   b. All emergency services provided by a provider or a ~~nonprovider~~ noncontracting provider for a member enrolled with the IHS or receiving services from a Tribal Facility, and
3. Facilitate follow-up treatment.

H. As specified in A.R.S. §§ 36-2986 and 36-2992, the IHS or a Tribal Facility shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

R9-31-1602. General Requirements for Scope of Services

A. In addition to the requirements and the limitations specified in this Chapter, the following general requirements apply:
1. As specified in A.R.S. § 36-2989 and R9-31-1625, covered services provided to a member shall be medically necessary and provided by, or under the direction of, the IHS, a Tribal Facility, a provider, or a dentist. Specialist services shall be provided under referral from the IHS or a Tribal Facility provider.
2. If the IHS cannot provide a covered service due to the circumstances delineated in the signed Settlement Agreement CV-86-1105-PHX-RGS, a member shall be referred to a non-IHS provider or a non-IHS facility for the service and a referral form shall be completed and referred to the Administration based on procedures established by the Administration.
3. Experimental services as determined by the Director, or services provided primarily for the purpose of research, shall not be covered;
4. Services or items, if furnished gratuitously, are not covered and payment shall be denied;
5. Personal care items are not covered and payment shall be denied; and
6. Services shall not be covered if provided to:
   a. An inmate of a public institution,
   b. A person who is a resident of an institution for the treatment of tuberculosis,
   c. A person who is in an institution for the treatment of mental diseases at the time of application or at the time of redetermination, or
   d. A person prior to the date of eligibility.

B. Services shall be provided by AHCCCS registered personnel or facilities which are appropriately licensed or certified to provide the services.

C. Payment for services or items requiring prior authorization as defined in this Article may be denied if prior authorization from the Administration is not obtained. Emergency services do not require prior authorization.

1. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization.
2. Written documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.

D. As specified in A.R.S. § 36-2989, covered services rendered to a member shall be provided within the service area of the IHS or a Tribal Facility except when:
1. An IHS or a Tribal Facility refers a member out of the area for medical specialty care or behavioral health services,
2. A covered service that is medically necessary for a member is not available within the service area,
3. A member is placed in an NF located out of the service area.

E. If a member requests the provision of a service that is not covered by the program or not authorized by the IHS or a Tribal Facility, the service may be rendered to a member by an AHCCCS-registered service provider under the following conditions:
1. A document lists the requested services and the itemized cost of each is prepared by a provider or a ~~nonprovider~~ non-contracting provider and provided to a member, and
2. The signature of a member is obtained in advance of service provision indicating that the services have been explained to a member and that a member accepts responsibility for payment.

F. Noncovered services provided to a member by the IHS, a Tribal Facility or under referral may be paid by the IHS or a Tribal Facility, but not with Title XXI funds.

R9-31-1610. Transportation Services

~~**A.** Emergency ambulance services.~~
~~1. As specified in A.R.S. § 36-2989, emergency ambulance transportation services shall be a covered service for a member. Payment shall be limited to the cost of transporting a member in a ground or air ambulance:~~
~~a. To the nearest appropriate provider or medical facility capable of meeting a member's medical needs, and~~
~~b. When no other means of transportation is both appropriate and available.~~
~~2. A ground or an air ambulance transport that originates in response to a 9-1-1 call or other emergency response system shall be reimbursed by the Administration for a member if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior authorization is required for reimbursement of these transports.~~
~~3. Determination of whether transport is medically necessary shall be based upon the medical condition of a member at the time of transport.~~
~~4. Notification to the Administration of emergency transportation provided is not required but a provider shall submit documentation with the claim which justifies the service.~~
~~**B.** Air ambulance services shall be covered only if:~~
~~1. The air ambulance transport is initiated upon the request of an emergency response unit, a law enforcement official, a hospital, a clinic medical staff member, the IHS or a Tribal Facility provider, a physician, or a practitioner;~~
~~2. The point of pickup is inaccessible by ground ambulance, or great distances, or other obstacles are involved in getting emergency services to a member or transporting a member to the nearest hospital or other provider with appropriate facilities; and~~
~~3. The medical condition of a member requires timely ambulance service and ground ambulance service will not suffice.~~
~~**C.** Medically necessary member transfers provided by an emergency air or a ground transportation provider may be covered when a member receiving inpatient services requires transport to another level of care or requires round trip transport to another facility to obtain necessary specialized diagnostic treatment services if:~~
~~1. A member's condition is such that the use of any other method of transportation would be harmful to a member's health, and~~
~~2. Services are not available in the facility where a member is a patient.~~
~~**D.** Meals, lodging and escort services.~~
~~1. Expenses for meals and lodging for a member while en route to, or returning from, an approved and prior authorized health care service site out of a member's service area shall be a Title XXI covered service.~~
~~2. Expenses of an escort, who may be a family household member accompanying a member out of a member's service area shall be covered if the services of an escort are ordered in writing by an IHS or a Tribal Facility provider, an attending physician or a practitioner.~~
~~3. Meals, lodging and escort services provided by a provider shall be prior authorized by the Administration.~~
~~**E.** Limitations.~~
~~1. Expenses shall be allowed only when a member requires a covered service that is not available in the service area;~~
~~2. If a member is admitted to an inpatient facility, expenses for an escort shall be covered only when accompanying a member en route to, and returning from, the inpatient facility; and~~
~~3. A salary for an escort shall be covered if an escort is not a part of a member's family household.~~
~~**F.** Non-emergency transportation services are not covered as specified in A.R.S. § 36-2989.~~

The Administration shall provide transportation services under A.A.C. R9-22-211.

R9-31-1617. Prior Authorization

A provider and a ~~nonprovider~~ noncontracting provider shall request prior authorization from the Administration according to this Article. The following inpatient hospital services provided to a member enrolled with the IHS out of the IHS or a Tribal Facility require prior authorization from the Administration:

1. Nonemergency and elective admission, shall be authorized prior to admission;
2. Elective surgery, excluding voluntary sterilization, shall be authorized prior to the surgery;
3. An emergency hospitalization that exceeds 3 days or an intensive care admission that exceeds 1 day;
4. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through the Administration's concurrent team review; and
5. Services or items furnished to cosmetically reconstruct appearance after the on-set of trauma or serious injury shall be authorized prior to service delivery.

R9-31-1618. Claims

A. Claims submission to the Administration.

1. The IHS, a Tribal Facility, a TRBHA, or a provider under referral shall ensure that a claim for covered services provided to a member is initially received by the Administration not later than 6 months from the date of service. The Administration shall deny a claim not received within the 6-month period from the date of service. If a claim meets the 6-month limitation, the IHS, a Tribal Facility, a TRBHA, or a provider under referral shall file a clean claim which is received by the Administration not later than 12 months from the date of service.
2. The 6- and 12-month deadlines for an inpatient hospital claim begin on the date of discharge for each claim.

B. Claims processing.

1. If a claim contains erroneous or conflicting information, exceeds parameters, fails to process correctly, does not match the Administration's files, or requires manual review to be resolved, the Administration shall report the claim to a provider with a remittance advice.
2. The Administration shall process a hospital claim in accordance with A.A.C. R9-22-712.

C. Overpayments for Title XXI services. An IHS or a Tribal Facility provider, a ~~nonprovider~~ noncontracting provider, or a Tribal Facility, shall notify the Administration if a Title XXI overpayment is made. The Administration shall recoup an overpayment from a future claim cycle, or, at the discretion of the Director, require the IHS or a Tribal Facility provider or a ~~nonprovider~~ noncontracting provider, to return the incorrect payment to the Administration.

R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care

A. Liability to the Administration for an emergency medical condition of a member who is provided care outside the IHS or a Tribal Facility's service area shall be subject to reimbursement only until a member's condition is stabilized and a member is transferable, or until a member is discharged following stabilization subject to the requirements of A.R.S. § 36-2989.

B. Subject to subsection (A), if a member cannot be transferred following stabilization to the IHS or a Tribal Facility, the Administration shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided to a member before the date of discharge or transfer according to payment standards in R9-31-705.

C. If a member refuses transfer from a ~~nonprovider~~ noncontracting provider or a noncontracting hospital to the IHS or a Tribal Facility, the Administration shall not be liable for any costs incurred after the date of refusal if:

1. After consultation with a member's IHS or a Tribal Facility, a member continues to refuse the transfer; and
2. A member has been provided and signs a written statement, before the date of transfer of liability, informing a member of the medical and financial consequences of refusing to transfer. If a member refuses to sign a written statement, a statement signed by 2 witnesses indicating that a member was informed may be substituted.

R9-31-1625. Behavioral Health Services

A. The IHS, a contractor, a TRBHA, a RBHA or a Tribal Facility may provide any or all of the behavioral health services specified in 9 A.A.C. 31, Article 12, subject to the limitations and specifications stated in 9 A.A.C. 31, Article 12, to a Native American who is eligible for Title XXI services.

~~**B.** It is the responsibility of the IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA to monitor the limitations and specifications prescribed in 9 A.A.C. 31, Article 12. Services provided in excess of the limitations and specifications prescribed in 9 A.A.C. 31, Article 12 shall not be reimbursed by the Administration.~~

~~**C.**~~**B.** The IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA shall cooperate as specified in contract, IGA, or this Chapter when the transition from 1 entity to another becomes necessary. ~~For a Title XXI member, this transition shall include tracking and reporting of services used by a member toward the annual limitations prior to the transfer of care.~~

~~**D.**~~**C.** The IHS and a Tribal Facility shall be considered a provider for the provision of behavioral health services and shall be subject to the requirements of:

1. A TRBHA if 1 is operating in a service area, or

2. A RBHA in a service area that does not have a TRBHA or a contractor for a Native American member with respect to prior authorization and service authorizations.

~~E.~~**D.** If either the IHS or a Tribal Facility cannot provide a nonemergency inpatient or an outpatient behavioral health service, the IHS or a Tribal Facility shall refer the member to a RBHA or a TRBHA.

~~F.~~**E.** ~~Behavioral health emergency and crisis stabilization services shall be handled as follows:~~ If a member is enrolled with a contractor and is not enrolled with a TRBHA or a RBHA, the contractor is responsible for the provision of emergency behavioral health services for up to three days per admission, not to exceed 12 days per contract year, and shall refer a member to a TRBHA or a RBHA.

~~1. If a member is enrolled with the IHS or a contractor and is not enrolled with a TRBHA or a RBHA, the IHS or a contractor is responsible for the provision of emergency behavioral health services for up to 3 days per admission, not to exceed 12 days per contract year, and shall refer a member to a TRBHA or RBHA.~~

~~2. Inpatient service limitations shall apply to emergency or crisis stabilization services provided on an inpatient basis.~~

~~3. Emergency or crisis intervention services provided on an outpatient basis by a psychiatrist, a certified psychiatric nurse practitioner, a psychologist, or a qualified facility shall not count towards the outpatient service limitation.~~

~~G.~~**F.** Prior authorization must be obtained for all inpatient hospitalizations and partial care services as authorized in R9-31 1202 and R9-31-1203.

~~H.~~**G.** A provider shall comply with the requirements specified in subsections (B)~~,~~ and (C)~~, and (D)~~ or payment may be denied, or if paid, may be recouped by the Administration.

~~I.~~**H.** A behavioral health service provided by the IHS or a Tribal Facility shall be reimbursed as specified in R9-31-1616.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) CHILDREN'S HEALTH INSURANCE PROGRAM

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Article 4	Repeal
Article 6	Amend
R9-31-601	Amend
R9-31-602	New Section
R9-31-603	New Section
R9-31-604	New Section
R9-31-605	New Section
R9-31-606	New Section
R9-31-701	Amend
R9-31-709	Amend
R9-31-714	New Section
R9-31-716	Amend
R9-31-717	New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. §§ 36-2982 and 36-2986
Implementing statute: A.R.S. §§ 36-2982 and 36-2986

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 2527, June 15, 2001

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

5. An explanation of the rule, including the agency's reasons for initiating the rule:

These rules define the contracts/RFP process for AHCCCS' children's health insurance program. The Administration is amending these rules to make the rules more clear, concise, and understandable and comply with the January 2002 G.R.R.C. deadline for the five-year review.

6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

The contractors, members, and the Arizona Health Care Cost Containment System Administration (AHCCCSA) will be nominally impacted by the changes to the rule language. The Administration is amending these rules to:

Increase clarity and conciseness,

Add performance measurement language in accordance with statute, and

Remove language that is more appropriate in contract.

There will be no fiscal impact on businesses or political subdivisions since the proposed rule language changes are nonsubstantive and are intended to streamline and clarify the existing rules. Articles 4 and 6 are combined to increase clarity and conciseness. Language that does not clearly present policies or procedures is clarified. Citations to documents incorporated in the rule are updated, as needed. The performance measurement language clarifies existing statutory authority. Duplicative language that appropriately exists in contract is deleted. There will be a minor impact for the cost of printing the copies for the rule, once adopted and approved.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: October 2, 2001

Time: 9:00 a.m.

Location: AHCCCS
701 E. Jefferson, Gold Room
Phoenix, AZ 85034

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location: Yuma City Hall, City Council Chambers
180 W. 1st. St.

Yuma, AZ 85364

Parking: Parking is next door at the Armory.

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location: ALTCS: Arizona Long Term Care System
484 E. Wilcox Drive
Sierra Vista, AZ 85635

Nature: Public Hearing

Date: October 2, 2001

Time: 9:00 a.m.

Location: ALTCS: Arizona Long Term Care System
110 S. Church, Suite 3250
Tucson, AZ 85701

Nature: Video Conference Oral Proceeding

Date: October 2, 2001

Time: 9:00 a.m.

Location: ALTCS: Arizona Long Term Care System
3480 E. Route 66
Flagstaff, AZ 86004

Nature: Video Conference Oral Proceeding

The Administration shall accept written comments until 5:00 p.m., Tuesday, October 2, 2001.
Please submit comments at the public hearing listed above or to the following person:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 420
Phoenix, AZ 85034

Telephone: (602) 417-4534

Fax: (602) 256-6756

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

Not applicable

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 4. ~~CONTRACTS~~ REPEALED

Section
R9-31-401. ~~General Provisions~~ Repealed
R9-31-402. ~~Administration's Contracts with Contractors~~ Repealed
R9-31-403. ~~Subcontracts~~ Repealed
R9-31-404. ~~Contract Amendments; Mergers; Reorganizations~~ Repealed
R9-31-405. ~~Suspension, Denial, Modification, or Termination of Contract~~ Repealed
R9-31-406. ~~Contract: Sanction; Performance; and Solvency~~ Repealed
R9-31-407. ~~Contract or Protest, Appeal~~ Repealed

ARTICLE 6. ~~REQUEST FOR PROPOSAL (RFP)~~ RFP AND CONTRACT PROCESS

Section
R9-31-601. General Provisions ~~for RFP~~
R9-31-602. RFP
R9-31-603. Contract Award
R9-31-604. Contract or Proposal Protests; Appeals
R9-31-605. Waiver of Contractor's Subcontract with Hospitals
R9-31-606. Contract Compliance Sanction

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-31-701. ~~General;~~ Scope of the Administration's Liability~~; and Payment to a Contractor~~
R9-31-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care
R9-31-714. ~~Reserved~~ Payments to Providers
R9-31-716. Specialty Contracts
R9-31-717. Contractor Performance Measure Outcomes

ARTICLE 4. ~~CONTRACTS~~ REPEALED

R9-31-401. ~~General Provisions~~ Repealed

~~**A.** Administration and contract authority. The Administration shall administer the program as specified in A.R.S. § 36-2982.~~

~~**B.** Rule authority. The Director has full operational authority to use the appropriate rules adopted for contract administration and oversight of contractors as specified in A.R.S. § 36-2986.~~

~~**C.** For purposes of this Chapter, as specified in A.R.S. § 36-2981, contractor includes the following:~~

~~1. A health plan as specified in A.R.S. § 36-2981; or~~

~~2. A qualifying plan as specified in A.R.S. § 36-2981 and that provides services to members as specified in A.R.S. § 36-2989.~~

~~**D.** Exemption from procurement process. The Administration is exempt from the procurement code as specified in A.R.S. §§ 36-2988 and 41-2501.~~

~~**E.** Contractor's financial responsibility. The Administration shall specify in contract when a person who has been determined eligible will be enrolled with a contractor and the date on which the contractor will be financially responsible for health and medical services to the person as specified in A.R.S. § 36-2987.~~

~~**F.** Contract. A contract may be canceled or rejected in whole or in part as specified in contract if it is deemed by the Director to be in the best interest of the state. The reasons for cancellation or rejection shall be made part of the contract file.~~

~~**G.** Damages or claims. Offerors shall have no right to damages or basis for any claims against the state, its employees, or agents, arising out of any action by the Administration according to the provisions of subsection (F).~~

~~**H.** Ownership interest. A contractor shall not knowingly have a director, officer, partner, or person with ownership of more than 5% of the contractor's equity who has been debarred or suspended by any federal agency, as specified in 42 U.S.C. 1396u-2, as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future additions or amendments.~~

~~**I.** Certification. The Administration shall certify a contractor as a risk-bearing entity as specified in 42 U.S.C. 1396b(m), as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future additions or amendments.~~

R9-31-402. ~~Administration's Contracts with Contractors~~ Repealed

~~**A.** Contracts with the Administration. The Administration shall use contractors that have a contract with the Administration to provide services to members who qualify for the program as specified in A.R.S. § 36-2988.~~

~~**B.** Conditions when the Administration is a contractor. The Director may require contract terms allowing the Administration to operate a contractor directly under circumstances specified in the contract according to A.R.S. § 36-2986.~~

~~**C.** Expansion or contraction of services or services areas. The Director may negotiate with any successful bidder for the expansion or contraction of services or service areas, after contracts have been awarded as specified in A.R.S. § 36-2988.~~

~~**D.** Amending contracts. The Administration has full authority to amend existing contracts awarded in compliance with A.R.S. § 36-2988.~~

~~**E.** Content of contract. Each contract between the Administration and a contractor shall be in writing and contain at least the following information:~~

~~1. The method and amount of compensation or other consideration to be received by the contractor.~~
~~2. The name and address of the contractor.~~
~~3. The population to be covered by the contractor.~~
~~4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid for Title XXI coverage.~~
~~5. The term of the contract, including the beginning and ending dates, as well as methods of extension, renegotiation, and termination.~~
~~6. A provision that the Director may evaluate, through inspection or other means, the quality, appropriateness, or timeliness of services performed under the contract.~~
~~7. A description of the eligibility requirements for a Title XXI member, medical and cost record-keeping systems, and a provision that the Director may audit and inspect any of the contractor's records that pertain to services performed and determinations of amounts payable under the contract. These records shall be maintained by the contractor for 5 years from the date of final payment or, for records relating to costs and the date of final payment or, for records relating to costs and expenses to which the Administration has taken exception, 5 years after the date of final disposition or resolution of the exception.~~
~~8 A provision that contractors maintain all forms, records, and statistical information required by the Director for purposes of audit and program management. This material, including files, correspondence, and related information pertaining to services rendered or claims for payments shall be subject to inspection and copying by the Administration or by the Department of Health and Human Services during normal business hours at the place of business of the person or organization maintaining the records.~~
~~9. A provision that the contractor safeguard information.~~
~~10. Any activities to be performed by the contractor affecting members that are related to 3rd-party liability requirements prescribed in A.R.S. § 36-2986.~~
~~11. Functions that may be subcontracted, including a provision that any subcontract meets the requirements of 42 CFR 434.6, as of December 30, 1983, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~
~~12. A provision that the contractor arrange for the collection of any required copayment by the provider.~~
~~13. A provision that the contractor will not bill or attempt to collect from a Title XXI member for any covered service except as authorized by statute or these rules.~~
~~14. A provision that the contract will not be assigned or transferred without the prior approval of the Director.~~
~~15. Procedures for enrollment or re-enrollment of a covered population.~~
~~16. Procedures and criteria for terminating the contract.~~
~~17. A provision that any cost sharing requirements imposed for services furnished to members are in accordance with A.R.S. § 36-2982, and 42 CFR 447.50 through 447.58, as of December 19, 1990, which are incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains Procedures for terminating enrollment and choice of health professional.~~
~~18. Procedures for teminating enrollment and choice of health professional.~~
~~19. A provision that specifies the rates are actuarially sound.~~
~~20. A provision that a contractor provide for an internal grievance procedure that:~~
~~a. Is approved in writing by the Administration;~~
~~b. Provides for prompt resolution; and~~
~~c. Ensures the participation of individuals with authority to require corrective action.~~
~~21. A provision that the contractor maintain an internal quality management system consistent with A.R.S. § 36-2986 and Title XXI rule and policy as specified in R9-31-522.~~
~~22. A provision that the contractor submit marketing plans, procedures, and materials to the Administration for approval before implementation.~~
~~23. A statement that all representations made by contractors, or authorized representatives are truthful and complete to the best of their knowledge.~~
~~24. A provision that the contractor is responsible for all:~~
~~a. Tax obligations;~~
~~b. Worker's Compensation Insurance; and~~
~~c. All other applicable insurance coverage, for itself and its employees, and that the Administration has no responsibility or liability for any of the taxes or insurance coverage.~~

~~25. A provision that the contractor agrees to comply with all applicable statutes and rules.~~

R9-31-403. ~~Subcontracts~~ Repealed

~~**A.** Approval. A contractor entering into a subcontract to provide services to a Title XXI member must meet the requirements specified in the contract. Any amendment to a subcontract shall be subject to review and approval by the Director. No subcontract alters the legal responsibility of a contractor to the Administration to ensure that all activities under the contract are carried out.~~

~~**B.** Subcontracts. Each subcontract shall be in writing and include a:~~

~~1. Provision that the subcontract is to be governed by, and construed in accordance with all laws, rules, and contractual obligations of the contractor.~~
~~2. Provision to notify the Administration in the event the subcontract is amended or terminated.~~
~~3. Provision that assignment or delegation of the subcontract is voidable, unless prior written approval is obtained from the Administration.~~
~~4. Provision to hold harmless the state, the Director, the Administration, and a Title XXI member in the event the contractor cannot or will not pay for covered services performed by the subcontractor.~~
~~5. Provision that the subcontract and subcontract amendments are subject to review and approval by the Director as established in these rules and that a subcontract or subcontract amendment may be terminated, rescinded, or canceled by the Director for a violation of these rules.~~
~~6. Provision to hold harmless and indemnify the state, the Director, the Administration, or a Title XXI member against claims, liabilities, judgments, costs and expenses with respect to third parties, which may accrue against the state, the Director, the Administration, or a Title XXI member, through the negligence of the subcontractor.~~
~~7. Provision that a Title XXI member is not to be held liable for payment to a provider in the event of contractor's bankruptcy; and~~
~~8. Provision that the requirements contained in R9-31-402(E)(1) through (E)(10) and (E) (13), (14), (16), (20), (23), (24), (25) apply but substitute the term "subcontractor" wherever the term "contractor" is used.~~

~~**C.** Waiver. A contractor may submit a written request to the Administration requesting a waiver of the requirement that the contractor subcontract with a hospital in the contractor's service area. The request shall state the reasons a waiver is believed to be necessary and shall state all efforts the contractor has made to secure a subcontract. For good cause shown, the Administration may waive the hospital subcontract requirement. The Administration shall consider the following criteria in deciding whether to waive the hospital subcontract requirement:~~

~~1. The number of hospitals in the service area.~~
~~2. The extent to which the contractor's primary care physicians have staff privileges at noncontracting hospitals in the service area.~~
~~3. The size and population of, and the demographic distribution within, the service area.~~
~~4. Patterns of medical practice and care within the service area.~~
~~5. Whether the contractor has diligently attempted to negotiate a hospital subcontract in the service area.~~
~~6. Whether the contractor has any subcontracts in adjoining service areas with hospitals that are reasonably accessible to the contractor's members in the service area.~~
~~7. Whether the contractor's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.~~

R9-31-404. ~~Contract Amendments; Mergers; Reorganizations~~ Repealed

~~Any merger, reorganization, or change in ownership of a contractor shall require that the contractor submit the contract between the Administration and the contractor for amendment and prior approval by the Director. Additionally, any merger, reorganization, or change in ownership of a subcontractor that is related to or affiliated with the contractor shall constitute a contract amendment which requires the prior approval of the Director. To be effective, contract amendments shall be in writing and executed by the Director.~~

R9-31-405. ~~Suspension, Denial, Modification, or Termination of Contract~~ Repealed

~~**A.** General. The Director may suspend, deny, refuse or fail to renew, or terminate a contract or subcontract for good cause as specified in contract.~~

~~**B.** Modification and termination of the contract without cause. The Administration and contractor by mutual consent may modify or terminate the contract at any time without cause. Additionally, the Administration may terminate or suspend the contract in whole or in part without cause effective 30 days after mailing written notice of termination or suspension by certified mail, return receipt requested to the contractor.~~

~~**C.** Notification.~~

~~1. The Director shall provide the contractor written notice of intent to:~~
~~a. Suspend;~~
~~b. Deny;~~
~~c. Fail to renew; or~~

~~d. Terminate a contract or related subcontract.~~

~~2. The Administration shall provide a notice to an affected principal, an enrolled member and an other interested party, and shall include:~~

~~a. The effective date; and~~

~~b. Reason for the action.~~

~~3. The Administration shall immediately stop processing all applications and shall provide 30 days advance notice to a contractor that the program will terminate on the 1st day of the following month after notice is served, if the federal government:~~

~~a. Eliminates federal funding for the program; or~~

~~b. Significantly reduces the federal funding below the estimated federal expenditures according to A.R.S. § 36-2985.~~

~~**D.** Records.~~

~~1. All medical, financial, and other records shall be retained by a terminated contractor in accordance with state laws and rules. Medical records or copies of medical records may be required to be submitted to the Director, or designee, within 10 working days of the effective date of contract termination.~~

~~2. All contract records shall be retained for a period of 5 years and disposed of as specified in A.R.S. § 36-2986.~~

R9-31-406. ~~Contract: Sanction; Performance; and Solvency~~ Repealed

~~**A.** The Director may impose a sanction upon a contractor that violates any provision of the rules as specified in contract.~~

~~**B.** Adequate performance. The Director shall require contract terms that are necessary to ensure adequate performance by the contractor as specified in A.R.S. § 36-2986 and 9 A.A.C. 31, Article 5.~~

~~**C.** Solvency. The Director shall establish solvency requirements in contract as specified in A.R.S. § 36-2986 and 9 A.A.C. 31, Article 5.~~

R9-31-407. ~~Contract or Protest, Appeal~~ Repealed

~~The contractor shall file a grievance as specified in A.A.C. R9-22-804.~~

ARTICLE 6. ~~REQUEST FOR PROPOSAL (RFP)~~ RFP AND CONTRACT PROCESS

R9-31-601. General Provisions ~~for RFP~~

A. The Director has full operational authority to adopt rules or to use the appropriate rules for contract administration and oversight of contractors ~~as specified in~~ under A.R.S. § 36-2986. The Administration shall administer the program under A.R.S. § 36 -2982.

B. The Administration shall award contracts under A.R.S. § 36-2986 to provide services under A.R.S. § 36-2989.

~~B.~~C. The Administration shall follow the provisions ~~specified in~~ under 9 A.A.C. 22, Article 6 for ~~offerors and are~~ children's health insurance program members, ~~subject to the limitations and exclusions specified in that Article,~~ unless otherwise specified in this Chapter. All references to the Administration also shall apply to the children's health insurance program.

D. For this Chapter, "contractor" is defined in A.R.S. § 36-2981.

E. The Administration is exempt from the procurement code under A.R.S. § 36-2988.

F. The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2986 and dispose of the records under A.R.S. § 41-2550.

R9-31-602. RFP

The RFP for a contractor serving members who qualify for the children's health insurance program shall be under A.R.S. § 36-2986 and A.A.C. R9-22-602.

R9-31-603. Contract Award

The contract award shall be under A.R.S. § 36-2986 and A.A.C. R9-22-603.

R9-31-604. Contract or Proposal Protests; Appeals

Contract or proposal protests or appeals shall be under A.A.C. R9-22-604. All references in that rule shall apply.

R9-31-605. Waiver of Contractor's Subcontract with Hospitals

A waiver of a contractor's subcontract with hospitals shall be under A.A.C. R9-22-605.

R9-31-606. Contract Compliance Sanction

The Administration shall follow sanction provisions under A.A.C. R9-22-606 and all references in that rule shall apply.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-31-701. ~~General;~~ Scope of the Administration's Liability~~; and Payment to a Contractor~~

A. The Director has full operational authority to adopt rules or to use the appropriate rules adopted for the development and management of a contractor payment system ~~as specified in~~ under A.R.S. §§ 36-2986 and 36-2987.

B. If the federal government eliminates federal funding for the program or significantly reduces the federal funding below the estimated federal expenditures, the Administration shall immediately stop processing all applications and shall provide at least 30 days advance notice to contractors and members that the program shall terminate ~~as specified in~~ under A.R.S. § 36-2985.

C. The Administration shall bear no liability for providing covered services to or completing a plan of treatment for any member beyond the date of termination of the member's eligibility. ~~or enrollment as specified in A.R.S. § 36-2987.~~

~~**D.** The Administration shall make all payments to a contractor in accordance with the terms and conditions of the contract executed between the contractor and the Administration and in accordance with these rules as specified in A.R.S. § 36-2986.~~

~~**E.** The Administration shall bear no liability for subcontracts that a contractor executes with other parties for the provision of administrative or management services, medical services, or covered health care services, or for any other purpose. A contractor shall indemnify and hold the Administration harmless from any and all liability arising from the contractor's subcontracts, shall bear all costs of defense of any litigation over the liability, and shall satisfy in full any judgment entered against the Administration in litigation involving the contractor's subcontracts.~~

~~**F.** The Administration shall make capitation payments monthly to a contractor who meets the requirements in A.R.S. § 36-2987.~~

R9-31-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care

~~**A.** For purposes of program and contractor liability, an emergency medical or acute mental health condition of a member shall be subject to reimbursement only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of A.R.S. § 36-2989 and Article 2 of this Chapter.~~

~~**B.** Subject to subsection (A), if a member cannot be transferred following stabilization to a facility that has a subcontract with the contractor of record, the contractor of record shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided the member before the date of discharge or transfer in accordance with payment standards in R9-31-705.~~

~~**C.** If a member refuses transfer from a nonprovider or noncontracting hospital to a hospital affiliated with the member's contractor of record, neither the Administration nor the contractor shall be liable for any costs incurred after the date of refusal if:~~

~~1. After consultation with the member's contractor of record, the member continues to refuse the transfer; and~~

~~2. The member has been provided and signs a written statement, before the date of transfer of liability, informing the member of the medical and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by 2 witnesses indicating that the member was informed may be substituted.~~

A contractor's liability to hospitals for the provision of emergency and subsequent care shall be under A.R.S. § 36-2989, A.A.C. R9-22-709, R9-31-705, and Article 2 of this Chapter. All references in these rules shall apply.

R9-31-714. ~~Reserved~~ Payments to Providers

The Administration shall pay providers under A.A.C. R9-22-714.

R9-31-716. Specialty Contracts

~~The Director may at any time negotiate or contract on behalf of contractors for specialized hospital and medical services including, but not limited to, transplants, neonatology, neurology, cardiology, and burn care. If the Director contracts for specialized services, contractors of record may be required to include the services within their delivery networks and make contractual modifications necessary to carry out this Section. Specialty contractors shall take precedence over all other contractual arrangements between contractors of record and their subcontractors. Specialty contractors may require interim payments to specialty contractors on behalf of contractors of record for contract services received by members. Interim payments to specialty contractors may be deducted from capitation payments, performance bonds, or other monies for payment on behalf of contractors of record. If the Administration and a hospital that performed a transplant surgery on a member does not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.~~

The Director may negotiate specialty contracts under A.A.C. R9-22-716.

R9-31-717. Contractor Performance Measure Outcomes

Contractor performance measure outcomes shall be under A.A.C. R9-22-719.

NOTICE OF PROPOSED RULEMAKING

TITLE 17. TRANSPORTATION

CHAPTER 5. DEPARTMENT OF TRANSPORTATION

COMMERCIAL PROGRAMS

PREAMBLE

1. Sections affected: **Rulemaking Action:**

R17-5-402	Amend
R17-5-403	New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 28-366

Implementing statute: A.R.S. §§ 28-4362, 28-5014

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 6 A.A.R. 3572, September 15, 2000

Notice of Recodification: 7 A.A.R. 3483, August 10, 2001

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Ellen Damron, Rules Analyst

Address: Department of Transportation
Administrative Rules Unit, Mail Drop 507M
3737 N. Seventh Street, Suite 160
Phoenix, Arizona 85014-5017

Telephone: (602) 7120-6722

Fax: (602) 241-1624

E-mail: edamron@dot.state.az.us

5. An explanation of the rule, including the agency's reasons for initiating the rule:

R17-5-402,identifies the specific bonding amounts necessary to accompany license applications for motor vehicle dealers, recyclers, and brokers, as prescribed in A.R.S. 28-4362. The Division has determined that dividing R17-5-402 into two rules provides clarity and understandability in the motor vehicle business license bonding process. R17-5-402, "Bond Amounts. Motor Vehicle Business Licenses", contains statutory changes of Laws 2001. R17-5-403, "Bond Amount. Title Services Motor Vehicle Business License", is prescribed by A.R.S. § 28-5014, and includes changes made to that law in Laws 2001. Further, R17-5-402 is also amended to reflect statutory changes as detailed in the Division's 5-year review, Governor's Regulatory Review Council docket #F-98-0401, approved on May 5, 1998. The amendment and new rule will meet the language requirements of both the Secretary of State and G.R.R.C.

NOTE: Since the initiation of rulemaking on these Sections, the agency has recodified 17 A.A.C. The Section was formerly designated R17-4-240.

6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

None

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

A motor vehicle business must provide a bond in an amount prescribed by these rules when applying to the Division for a business license. License applicants will pay a premium to a surety company to obtain the correct bond amount, which varies by the type of motor vehicle business. The Division bears the cost of licensure that includes confirmation of the validity and correctness of amount of a bond; the decision-making process for licensure; and resolving customer claims against a business and its bond.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Ellen Damron, Rules Analyst

Address:	Arizona Department of Transportation Administrative Rules Unit, Mail Drop 507M, 3737 N. 7th Street, Suite 160 Phoenix, Arizona 85014
Telephone:	(602) 712-6722
Fax:	(602) 241-1624
E-mail	edamron@dot.state.az.us
or	
Name:	Brenda Oddy
Address:	Dealer Licensing Manager Motor Vehicle Division 2739 E. Washington Phoenix, AZ 85034
Telephone:	(602) 712-7975
Fax:	(602) 712-3268
E-mail	boddy@dot.state.az.us

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: September 24, 2001

Time: 2:00 p.m.

Locations:

Flagstaff	**Phoenix**	**Tucson**
ADOT District Office Board Room 1801 S. Milton Rd. Flagstaff, AZ 86001	ADOT Headquarters Conference Room, 186 206 S. 17th Ave. Phoenix, AZ 85007	ADOT District Office Board Room 1221 S. 2nd Ave. Tucson, AZ 85713

Nature: Public hearing by videoconference

Closure: The public record in this rulemaking will close at 4:30 p.m. on October 5, 2001.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 17. TRANSPORTATION

CHAPTER 5. DEPARTMENT OF TRANSPORTATION
COMMERCIAL PROGRAMS

ARTICLE 4. DEALERS

Section

R17-5-402. ~~Dealer and wrecker bond amounts~~ Bond Amounts, Motor Vehicle Dealers, Brokers and Recyclers Business Licenses

R17-5-403. Bond Amount. Motor Vehicle Title Services Business License

ARTICLE 4. DEALERS

R17-5-402. ~~Dealer and wrecker bond amounts~~ Bond Amounts, Motor Vehicle Dealers, Brokers and Recyclers Business Licenses

~~Title 28, Chapter 8, Article 1, Arizona Revised Statutes provides that every application for a license to engage in the business of a motor vehicle dealer, motor dealer or wrecker shall be accompanied by a bond in a form to be approved by the Assistant Director and shall be in such amount, not less than $1,000, as the Assistant Director prescribes~~.

~~1. The minimum amount of such bonds shall be as follows:~~
   ~~a. Motor Vehicle Dealer dealing in motor vehicles other than motorcycles, motor-driven cycles or trailers with an unladen weight not exceeding 1500 lbs., $25,000.~~
   ~~b. Motor Vehicle Dealer dealing only in motorcycles, motor-driven cycles or trailers with an unladen weight not exceeding 1500 lbs., $10,000.~~
   ~~c. Motor Dealer -- $5,000.~~
   ~~d. Wrecker -- $5,000.~~
~~2. This Order to be effective as to bonds accompanying applications filed for the calendar year 1982 and thereafter.~~

A. As prescribed under A.R.S. § 28-4362, the Division shall require a bond in the amount specified for the following motor vehicle business license applicants:
1. $100,000 from a motor vehicle dealer engaged in selling new or used motor vehicles;
2. $50,000 from a wholesale motor vehicle dealer;
3. $50,000 from a wholesale motor vehicle auction dealer;
4. $25,000 from a motor vehicle broker; and
5. $20,000 from an automotive recycler.

B. An applicant shall submit a bond in a form prescribed by the Division Director. The Division shall not accept a handwritten bond.

R17-5-403 Bond Amount. Motor Vehicle Title Services Business License

A. As prescribed under A.R.S. § 28-5005, the Division shall require a $25,000 bond for a motor vehicle title service company applying for a business license.

B. An applicant shall submit a bond in a form prescribed by the Division Director. The Division shall not accept a handwritten bond.

NOTICE OF PROPOSED RULEMAKING

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 4. BANKING DEPARTMENT

PREAMBLE

1. Sections Affected **Rulemaking Action**

R20-4-102	Amend
R20-4-106	Amend
R20-4-107	Amend
R20-4-1805	Amend

2. The specific statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. §§ 6-123(2) and 41-1073

Implementing statute: A.R.S. §§ 6-123(4), 6-944, and 41-1073

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 6 A.A.R. 4451, November 24, 2000
Notice of Rulemaking Docket Opening: 7 A.A.R. 1563, April 13, 2001

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: John P. Hudock

Address: 2910 N. 44th Street, Suite 310, Phoenix, AZ 85018

Telephone: (602) 255-4421, ext. 167

Fax: (602) 381-1225

E-mail: jhudock@azbanking.com

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The rules in Article 1 have general applicability to all of Title 20, Chapter 4 of the *Arizona Administrative Code*. The rules in Article 18 concern Mortgage Bankers. This proceeding makes changes in both Articles, for several reasons.

Housekeeping changes are made in Article 1 that will improve the precision of the definition of the term "active management" and "branch office" and remove the numbers associated with each definitional subsection of R20-4-102.

Another non-substantive revision is the rewriting of R20-4-106, in fulfillment of a promise made to the Council in the last five-year rule review report that analyzed that rule.

The final revision of Article 1 is the addition of a time-frame for licensing Deferred Presentment Companies.

Finally, the amendment to R20-4-1805 corrects a drafting error that conflicts with the corresponding statute.

Details

Active Management
First, this rulemaking will revise the definition of "Active management" found in R20-4-102 to clarify that the definition applies to all the term's uses in statutory law administered by the Department, including those outside of A.R.S. Title 6, Chapter 9.

Records
Second, this rulemaking will amend R20-4-102 to add a definition of the term "Records."

Electronic Record
Third, this proceeding will amend R20-4-102 to add a definition of the term "Electronic Records."

Definitions no longer numbered
Fourth, this rulemaking will amend R20-4-102 to remove the numbering of the definitions in this Section, which are arranged alphabetically for ease of reference.

New licensing time-frame
Fifth, this proceeding will amend R20-4-107 to add a Licensing Time-frame for Deferred Presentment Companies, a newly created category of license.

R20-4-106 on Bankruptcy
Sixth, this rulemaking will make stylistic and editorial revisions to R20-4-106, the only Section in Article 1 not yet revised since acceptance of that Article's most recent 5-year-rule review.

Notice of changed address
Finally, this rulemaking will amend R20-4-1805 to reconcile it with statute. The present version of this Section requires the licensee to give the Superintendent notice of a change of business address within 5 days after the address changes. The statute, A.R.S. § 6- 944(D), specifies that the licensee shall notify the Superintendent before the change.

6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study, and other supporting material:

The Department does not propose to rely on any study as an evaluator or justification for the proposed rule.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

A. The Banking Department
The Department does not expect to experience any adverse economic impact. It will bear the administrative and human resources cost of this rulemaking. The amendment of these rules will not result in any significant cost savings for the Department. It will continue to bear the costs of enforcing the same requirements on its licensees. The increased clarity of the amended rules will make them marginally easier to understand and enforce.

B. Other Public Agencies
The State will incur normal review and publishing costs incident to rulemaking.

C. Private Persons and Businesses Directly Affected
Costs of services will not increase by any measurable degree. Nor should these revisions increase any licensee's cost of doing business in compliance with these rules. The revisions that allow the use of independent third parties to gather prospects for a licensee may actually decrease the cost of doing business. Under present rules, this task must be done by a licensee.

D. Consumers
No measurable effect on consumers is expected.

E. Private and Public Employment
The Department expects no measurable effect on private and public employment.

F. State Revenues
This rulemaking will not change state revenues.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	John P. Hudock
Address:	Department of Commerce 2910 N. 44th Street, Suite 310 Phoenix, AZ 85018
Telephone:	(602) 255-4421, ext.167
Fax:	(602) 381-1225
E-mail:	jhudock@azbanking.com

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

No oral proceedings are scheduled. The Department will schedule an oral proceeding on the proposed rule if it receives a written request for a proceeding within 30 days after the publication date of this notice, under the provisions of A.R.S. § 41-1023(C). Send requests to the Department personnel listed in this preamble's items 4 and 9. The

Department invites and will accept written comments on the proposed rule or the preliminary economic, small business, and consumer impact statement. Submit comments during regular business hours, at the address listed in this preamble's item #9, until the close of the record for this proposed rulemaking. The record will close on the 31st day following publication of this notice, unless the Department schedules an oral proceeding.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

There is no material incorporated by reference in these rules.

13. The full text of the rules follows:

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 4. BANKING DEPARTMENT

ARTICLE 1. GENERAL

Section
R20-4-102. Definitions
R20-4-106. Bankruptcy
R20-4-107. Licensing Time-frames ~~Time-Frames~~

ARTICLE 18. MORTGAGE BANKERS

Section
R20-4-1805. Notification of Change of Address

ARTICLE 1. GENERAL

R20-4-102. Definitions

In this Chapter, unless otherwise specified:

~~1.~~ "Active management" means directing a licensee's activities by a responsible individual, who:
  ~~a.~~ Is knowledgeable about the licensee's Arizona activities;
  ~~b.~~ Supervises compliance with:
    ~~i.~~ The laws enforced by the Banking Department ~~A.R.S. Title 6, Chapter 9~~ as they ~~it~~ relate ~~relates~~ to the licensee~~,~~; and
    ~~ii.~~ Other applicable laws and rules; and
  ~~c.~~ Has sufficient authority to ensure compliance.

~~2.~~ "Affiliate" has the meaning stated at A.R.S. § 6-901.

~~3.~~ "Attorney General" means the Attorney General or an assistant Attorney General of the State of Arizona.

~~4.~~ "Branch office" means any location within or outside Arizona, including a personal residence, but not including a licensee's principal place of business in Arizona, where the licensee holds out to the public that the licensee acts as a licensee ~~mortgage broker, mortgage banker, or commercial mortgage banker~~.

~~5.~~ "Business of a savings and loan association or savings bank" means receiving money on deposit subject to payment by check or any other form of order or request or on presentation of a certificate of deposit or other evidence of debt.

~~6.~~ "Compensation" means, in applying that term's definition in A.R.S. §§ 6-901, 6-941, and 6-971, anything received in advance, after repayment, or at any time during a loan's life. This subsection expressly excludes the following items from those definitions of compensation Compensation:
  ~~a.~~ Charges or fees customarily received after a loan's closing including prepayment penalties, termination fees, reinvestment fees, late fees, default interest, transfer fees, impound account interest and fees, extension fees, and modification fees. However, extension fees and modification fees are compensation if the lender advances additional funds or increases the credit limit on an open-end mortgage as part of the extension or modification;
  ~~b.~~ Out-of-pocket expenses paid to independent 3rd parties including appraisal fees, credit report fees, legal fees, document preparation fees, title insurance premiums, recording, filing, and statutory fees, collection fees, servicing fees, escrow fees, and trustee's fees;
  ~~c.~~ Insurance commissions;
  ~~d.~~ Contingent or additional interest, including interest based on net operating income; or
  ~~e.~~ Equity participation.

~~7.~~ "Commercial finance transaction," as that term is used in this Section's definitions of the terms "Engaged in the business of making mortgage loans" and "Engaged in the business of making mortgage loans or mortgage banking loans" ~~R20-4-102(13)~~, means a loan made primarily for other than personal, family, or household purposes.

~~8.~~ "Control of a licensee," as used in A.R.S. §§ 6-903(O), 6-944(A), or 6-978, does not include acquiring additional fractional equity interests in a licensee by any person who already has the power to vote 51% or more of the licensee's outstanding voting equity interests.

~~9.~~ "Correspondent contract," as that term is used in A.R.S. §§ 6-941, 6-943, 6-971, or 6-973, means an agreement between a lender and a funding source under which the funding source may fund, or is required to fund, loans originated by the lender.

~~10.~~ "Cushion," as that term is used in R20-4-1811 or R20-4-1908, means funds that a servicer or lender may require a borrower to pay into an escrow or impound account before the borrower's periodic payments are available in the account to cover unanticipated disbursements.

~~11.~~ "Directly or indirectly makes, negotiates, or offers to make or negotiate" and "Directly or indirectly making, negotiating, or offering to make or negotiate," as those phrases ~~that phrase~~ are ~~is~~ used in ~~either~~ A.R.S. §§ 6-901, 6-941, or 6-971, means:

~~a.~~ Providing consulting or advisory services in connection with a mortgage loan transaction, ~~a~~ mortgage banking loan transaction, or ~~a~~ commercial mortgage loan transaction;

~~i.~~ To an investor, concerning the location or identity of potential borrowers, regardless of whether the person providing consulting or advisory services ~~licensee~~ directly contacts any potential borrowers; or

~~ii.~~ To a borrower, concerning the location or identity of potential investors or lenders; or

~~b.~~ Providing assistance in preparing an application for a mortgage loan transaction, ~~a~~ mortgage banking loan transaction, or ~~a~~ commercial mortgage banking loan transaction, regardless of whether the person providing assistance ~~licensee~~ directly contacts any potential investor or lender; and,

~~c.~~ Processing a loan, but,

~~d.~~ "Directly or indirectly makes, negotiates, or offers to make or negotiate" and "Directly or indirectly making, negotiating, or offering to make or negotiate" do ~~does~~ not include:

~~i.~~ Providing clerical, mechanical, or word processing services to prepare papers or documents associated with a mortgage loan transaction, ~~a~~ mortgage banking loan transaction, or ~~a~~ commercial mortgage banking loan transaction;

~~ii.~~ Purchasing, selling, negotiating to purchase or sell, or offering to purchase or sell a mortgage loan, ~~a~~ mortgage banking loan, or ~~a~~ commercial mortgage banking loan already funded;

~~iii.~~ Making, negotiating, or offering to make additional advances on an existing open-ended mortgage loan, mortgage banking loan, or commercial mortgage loan including revolving credit lines;

~~iv.~~ Modifying, renewing, or replacing a mortgage loan, ~~a~~ mortgage banking loan, or ~~a~~ commercial mortgage loan already funded, if the parties to and security for the loan are the same as the original loan immediately before the modification, renewal, or replacement, and if no additional funds are advanced and no increase is made in the credit limit on an open-ended loan. Replacing a loan means making a new loan simultaneously with terminating an existing loan.

"Electronic record" has the meaning stated at A.R.S. § 44-7002(7).

~~12.~~ "Employee" means a natural person who has an employment relationship with a licensee that is acknowledged by both the person and the licensee, and:

~~a.~~ The person is entitled to payment, or is paid, by the licensee;

~~b.~~ The licensee withholds and remits, or is liable for withholding and remitting, payroll deductions for all applicable federal and state payroll taxes;

~~c.~~ The licensee has the right to hire and fire the employee and the employee's assistants;

~~d.~~ The licensee directs the methods and procedures for performing the employee's job;

~~e.~~ The licensee supervises the employee's business conduct and the employee's compliance with applicable laws and rules; and

~~f.~~ The rights and duties under subsections (a) through (e) belong to the licensee regardless of whether another person also shares those rights and duties.

~~13.~~ "Engaged in the business of making mortgage loans," as that phrase is used in A.R.S. § 6-902, and "Engaged in the business of making mortgage loans or mortgage banking loans," ~~means~~ as that phrase is used in A.R.S. §~~§ 6-902~~ or 6-942, means the direct or indirect making of a total of more than 5 mortgage banking loans or mortgage loans, or both in a calendar year. Each loan counts only once as of its closing date. A person is not "engaged in the business of making mortgage loans or mortgage banking loans" if the person makes loans solely in commercial finance transactions in which no more than 35% of the aggregate value of all security taken by the investor on the closing date is a lien, or liens, on real property.

~~14.~~ "Generally accepted accounting principles" has the meaning used by the Financial Accounting Standards Board or the American Institute of Certified Public Accountants.

~~15.~~ "Hold out to the public," as used in subsection (4), means advertising or otherwise informing the public that mortgage banking loans, commercial mortgage loans, or mortgage loans are made or negotiated at a location. "Hold out to the public" includes listing a location on business cards, stationery, brochures, rate lists, or other promotional items. "Hold out to the public" does not include a clearly identified home or mobile telephone number on a business card or stationery.

~~16.~~ "Loan," as that term is used in A.R.S. §§ 6-126(C)(6) and 6-126(C)(8) ~~6-126(C)(7)~~, means all loans negotiated or closed, without regard to the location of the real property collateral or type of loan.

~~17.~~ "Loan Processing" means obtaining a loan application's supporting documents for use in underwriting.

~~18.~~ "Person" means a natural person or any legal or commercial entity including a corporation, business trust, estate, trust, partnership, limited partnership, joint venture, association, limited liability company, limited liability partnership, or limited liability limited partnership.

~~19.~~ "Property insurance," as that term is used in A.R.S. §§ 6-909 and 6-947, does not include flood insurance as that term is used in the Flood Disaster Protection Act of 1973, as modified by the National Flood Insurance Reform Act of 1994. 42 U.S.C. 4001, et seq.

~~20.~~ "Reasonable investigation of the background," as that term is used in A.R.S. §§ 6-903, 6-943, or 6-976 means a licensee, at a minimum:

~~a.~~ Collects and reviews all the documents authorized by the Immigration Reform and Control Act of 1986, 8 U.S.C. 1324a;

~~b.~~ Obtains a completed Employment Eligibility Verification (Form I-9);

~~c.~~ Obtains a completed and signed employment application;

~~d.~~ Obtains a signed statement attesting to all of an applicant's felony convictions, including detailed information regarding each conviction;

~~e.~~ Consults with the applicant's most recent or next most recent employer, if any;

~~f.~~ Inquires regarding the applicant's qualifications and competence for the position;

~~g.~~ If for a loan officer, loan originator, loan processor, branch manager, supervisor, or similar position, obtains a current credit report from a credit reporting agency; and

~~h.~~ Investigates further if any information received in the above inquiries raises questions as to the applicant's honesty, truthfulness, integrity, or competence. An inquiry is sufficient after 2 attempts to contact a person, including at least 1 written inquiry.

"Record" has the meaning stated at A.R.S. § 44-7002(13).

~~21.~~ "Registered to do business in this state" means:

~~a.~~ If an Arizona corporation, it is incorporated under A.R.S. Title 10, Chapter 2, Article 1;

~~b.~~ If a foreign corporation, it either transfers its domicile under A.R.S. Title 10, Chapter 2, Article 2, or obtains authority to transact business in Arizona under A.R.S. Title 10, Chapter 15, Article 1;

~~c.~~ If a business trust, it obtains authority to transact business in Arizona under A.R.S. Title 10, Chapter 18, Article 4;

~~d.~~ If an estate, it acts through a personal representative duly appointed by this state's Superior Court, under the provisions of A.R.S. Title 14, Chapter 3 or 4;

~~e.~~ If a trust, it delivers to the Superintendent an executed copy of the trust instrument creating the trust together with:

~~i.~~ All the current amendments, or

~~ii.~~ A true copy of the trust instrument certified accurate and complete by a trustee of the trust before a notary public;

~~f.~~ If a general partnership, limited partnership, limited liability company, limited liability partnership, or limited liability limited partnership, it is organized under A.R.S. Title 29;

~~g.~~ If a foreign general partnership, limited partnership, limited liability company, limited liability partnership, or limited liability limited partnership, it is registered with the Arizona Secretary of State's office under A.R.S. Title 29;

~~h.~~ If a joint venture, association, or any entity not specified in this subsection, it is organized and conducts its business in compliance with Arizona law; or

~~i.~~ The entity is exempt from registration.

~~22.~~ "Resident of this state" means a natural person domiciled in Arizona.

~~23.~~ "Responsible individual" or "responsible person" as those terms are used in A.R.S. §§ 6-903, 6-943, 6-973, and 6-976, means a resident of this state who:

~~a.~~ Lives in Arizona during the entire period of designation as the responsible individual on a license;

~~b.~~ Is in active management of a licensee's affairs;

~~c.~~ Meets the qualifications listed in A.R.S. §§ 6-903, 6-943, or 6-973; and

~~d.~~ Is an officer, director, member, partner, employee, or trustee of a licensed entity.

R20-4-106. Bankruptcy

~~Upon the filing of a voluntary petition in bankruptcy or the filing against it of an involuntary petition in bankruptcy, any enterprise or consumer lender shall immediately notify the Superintendent of such action. The enterprise or consumer lender shall promptly provide the Superintendent with a copy of any petition for bankruptcy relief, schedule of assets and liabilities, statement of financial affairs, list of creditors, or plan of reorganization, filed in connection with such bankruptcy.~~

An enterprise licensee or consumer lender licensee shall immediately deliver written notice to the Superintendent if it files a voluntary bankruptcy petition, or if its creditors name the licensee a debtor in an involuntary bankruptcy petition. On the date of each of the following documents' filing with the bankruptcy court, the licensee shall deliver to the Superintendent a copy of the:

1. Petition for relief,
2. Schedule of assets and liabilities,
3. Statement of financial affairs,
4. List of creditors, and
5. Plan of reorganization.

R20-4-107. Licensing Time-frames ~~Time Frames~~

A. As used in this Section, "application ~~Application~~" means a document specified or described in this Title, or in any statute enforced by the Department, requesting any permit, certificate, approval, registration, charter, or similar permission described in Table A, together with all supporting documentation required by statute or rule.

B. The time-frames set forth in Table A apply solely to applications ~~Applications~~ received by the Department after the effective date of this Section. Each overall time-frame consists of an administrative completeness review time-frame, and a substantive review time-frame. The administrative completeness review time-frame begins to run upon receipt of an application ~~Application~~ by the Department.

1. Within the administrative completeness review time-frame set forth in Table A, the Department shall notify the applicant in writing whether the application ~~Application~~ is complete. If the application ~~Application~~ is incomplete, the notice shall specify the missing information or component.
2. An applicant ~~Applicant~~ whose application is incomplete shall supply the missing information within 60 days after the date of the notice. If an applicant shows good cause in writing before the expiration of the 60 day time limit, the Superintendent shall extend the period for administrative completion of an application ~~Application~~. The administrative completeness review time-frame stops running on the postmark date of the Department's written notice of an incomplete application, and resumes when the Department receives a complete application ~~Application~~. If the applicant fails to submit a complete application ~~Application~~ within the specified time limit, the Department shall reject the application ~~Application~~ and close the file. An applicant ~~Applicant~~ may reapply.
3. The substantive review time-frame begins to run on the postmark date of the Department's written notice that the application is administratively complete.
4. Within the overall time-frame set forth in Table A the Department shall send the applicant written notice of its decision to approve, conditionally approve, or deny a license, unless the time-frame is extended by mutual agreement under A.R.S. § 41-1075. If the Department denies an application ~~Application~~, it shall provide written justification for the denial and a written explanation of the applicant's right to a hearing or appeal in the form required by A.R.S. § 41-1076.
5. The Department shall calculate time limits prescribed in this Section under R2-19-107 ~~R20-4-1207(A)~~.

C. The time-frames in this Section apply solely to actions taken by the Department. Nothing in this Section relieves a licensee or applicant of a duty to fulfill any other legal or regulatory requirement that is a condition of its power and authority to engage in business.

Table A. Licensing Time-frames

No.	License Type	Legal Authority	Administrative Completeness Review (Days)	Substantive Review (Days)	Overall Time-Frame (Days)
1	Bank	A.R.S. § 6-203, et seq.			
	Initial Application	R20-4-211	45	45	90
2	Bank Trust Dept.	A.R.S. § 6-381			
	Initial Application	A.R.S. § 6-203, A.R.S. § 6-204(C)	45	45	90
3	Savings & Loan	A.R.S. § 6-401, et seq.			
	Initial Application	A.R.S. § 6-408, R20-4-327	75	75	150
4	Credit Union	A.R.S. § 6-501, et seq.			
	Initial Application	A.R.S. § 6-506(A)	60	60	120
5	Trust Company	A.R.S. § 6-851, et seq.			
	Initial Application	A.R.S. § 6-854(A)	75	75	150
6	Consumer Lender	A.R.S. § 6-601, et seq.			
	Initial Application	A.R.S. § 6-603(C)	60	60	120
7	Debt Management	A.R.S. § 6-701, et seq.			
	Initial Application	A.R.S. § 6-704(A), R20-4-602(A) R20-4-620(A)	30	30	60
8	Escrow Agent	A.R.S. § 6-801, et seq.			
	Initial Application	A.R.S. § 6-814	60	60	120
9	Mortgage Broker	A.R.S. § 6-901, et seq.			
	Initial Application	A.R.S. § 6-903(C)	60	60	120
10	Mortgage Banker	A.R.S. § 6-941, et seq.			
	Initial Application	A.R.S. § 6-943(D)	60	60	120
11	Commercial Mortgage Banker	A.R.S. § 6-971, et seq.			
	Initial Application	A.R.S. § 6-974(A)	60	60	120
12	Acquisition of Control of Financial Institution	R20-4-1602 R20-4-1702			
	Initial Application	A.R.S. § 6-1104	30	30	60
13	Money Transmitter	A.R.S. § 6-1201, et seq.			
	Initial Application	A.R.S. § 6-1204(A)	60	60	120
14	Advance Fee Loan Broker	A.R.S. § 6-1301, et seq.			
	Initial Application	A.R.S. § 6-1303(A)	30	30	60
15	Premium Finance Co.	A.R.S. § 6-1401, et seq.			
	Initial Application	A.R.S. § 6-1402(C)	60	60	120
16	Collection Agency	A.R.S. § 32-1001, et seq.			
	Initial Application	A.R.S. § 32-1021, R20-4-1502, R20-4-1530(A)	30	15	45
17	Motor Vehicle Dealer	A.R.S. § 44-281, et seq.			
	Dealer Application	A.R.S. § 44-282(B)	30	15	45
18	Sales Finance Co.	A.R.S. § 44-281, et seq.			
	Sales Finance Application	A.R.S. § 44-282(B)	30	15	45
19	Deferred Presentment Company	A.R.S. § 6-1259			
	Initial Application	A.R.S. § 6-1253	60	60	120

ARTICLE 18. MORTGAGE BANKERS

R20-4-1805. Notification of Change of Address

If a licensee changes the licensee's principal place of business, or the location of a branch office, the licensee shall notify the Superintendent at least ~~within~~ five business days before ~~after~~ the address change. With the notice, a licensee shall provide the Superintendent with the license for the office changing its address and the fee required by A.R.S. § 6-126 for changing an office address. A copy of the license shall continue to be displayed at the place of business until a new license is issued.